

DOCUMENT RESUME

ED 311 795

HE 022 844

AUTHOR Safian-Rush, Donna
TITLE Evaluation of a Six Week Professional Education Curriculum Designed To Retrain Registered Psychiatric Nurses into the Field of Psychiatric Nursing.
PUB DATE 89
NOTE 147p.
PUB TYPE Reports - Research/Technical (143) --
Tests/Evaluation Instruments (160) --
Legal/Legislative/Regulatory Materials (090)

EDRS PRICE MF01/PC06 Plus Postage.
DESCRIPTORS Enrollment Trends; Federal Legislation; Health Personnel; Higher Education; *Internship Programs; Medical Education; Mental Health; *Nurses; *Nursing Education; *Psychiatric Services; Questionnaires; Recruitment; *Retraining
IDENTIFIERS *Nursing Shortage Reduction Act 1989

ABSTRACT

During the past few years, there has been a drastic shortage of registered nurses in the field of psychiatric mental health. An evaluation conducted on an internship curriculum designed to facilitate effective nursing care in the treatment of clients who exhibit emotional problems is presented with details on a study to attract and retain nurses to employment opportunities in four Hospital Corporation of America (HCA) facilities via a 6-week internship program. Five sections are as follows: introduction; literature review (the nursing shortage, enrollments in nursing programs, need for psychiatric nurses, history of psychiatric nurses, shortage of psychiatric nurses, developmental education, and educational conceptual model); methodology; results; and discussion, implications, and recommendations. Results indicate that although all hard evidence gathered for a scientifically derived evaluation program revealed no significant differences, HCA is continuing to maintain the internship curriculum, since it serves as a powerful retention tool that is preventing a nursing shortage in HCA facilities. Four appendices are: the Nursing Shortage Reduction Act of 1987 S. 1402, text of the bill as reported; curriculum; and final exam for HCA internship nursing program. Tables and graphs are included. Contains 81 references. (SM)

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EVALUATION OF A SIX WEEK PROFESSIONAL EDUCATION CURRICULUM
DESIGNED TO RETRAIN REGISTERED PSYCHIATRIC NURSES INTO THE
FIELD OF PSYCHIATRIC NURSING

by

Dr. DONNA SAFIAN-RUSH RN ARNP

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ABSTRACT

During the past few years there has been a drastic shortage of registered nurses in the field. The shortage appears to have affected the field of psychiatric mental health nursing most intensely. The psychiatric nursing shortage is a multifaceted problem grounded in decreasing federal funds for advanced clinical training, inadequate under-graduate psychiatric experiences, lack of a well prepared articulate role model, the integrated curriculum and the confusion and blurring associated with the roles and functions of the psychiatric mental health nurse.

This dissertation will describe the current nursing shortage; the decline in enrollment to nursing programs; the history of psychiatric nursing as a discipline; the shortage of psychiatric mental health nurses; factors contributing to the psychiatric nursing shortage and a plan for a solution to the nursing shortage in psychiatry.

The paper focuses on an evaluation conducted on an internship curriculum designed to facilitate effective nursing care in the treatment of clients who exhibit emotional problems. The purpose of this study was to attract and retain nurses to employment opportunities in four Hospital Corporation of America (HCA) facilities, using a six week internship program.

The study will yield an analysis of the effect of combining psychodynamic principles and knowledge with skills in the clinical area. The demands of educational practice have been merged with the discipline of psychiatric nursing in the development of this curriculum.

Acknowledgements

To acknowledge adequately the very real contributions of interest, encouragement and advice given to me by so many faculty, friends, family, and colleagues would be an insurmountable task. I wish to thank those individuals who have been especially noteworthy in contributing to my endeavors throughout this dissertation process.

To my Committee Member, Dr. Shirley Belock, for her guidance, encouragement, and belief in me. I am grateful for having had the opportunity to work with such a distinguished scholar in the field of research. Her wisdom and support are deeply appreciated.

To my Committee Chairman, Dr. Stephan Fain, for his his concern, support, humor and motivation. His continuous encouragement help guide the development of this research.

I am grateful to the late Dr. James Wells, who served as a member of my committee. His sincerity and caring manner will be remembered always.

To my committee member, Dr. Donald Smith who has graciously agreed to take the place of Dr. Wells. I wish to extend my thanks for his thoughtful and most helpful participation in the preparation of this work.

To my brother, Richard Levinson, I can never thank him enough for his unconditional love, hours of help and continual devotion that he displayed through every page of this research.

And finally, I thank my son Matthew. Matthew has given me the will, drive and inspiration to achieve, so that I may make his life more rewarding.

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Chapter 1

Introduction

The current nursing shortage is a serious problem in our society. The registered nurse vacancy rates have more than doubled between 1983 and 1988 (from 4.4 percent to 11.3 percent). In fact seventy-six percent of all hospitals report at least some degree of shortage (DHHS, 1988).

Thirty percent of hospitals in urban areas and fifteen percent of rural hospitals report that they were forced to close beds in 1987 due to the nursing shortage (Florida Nursing News, 1988).

The United States Department of Health and Human Services (DHHS) stated that the reported shortage of registered nurses is real, widespread and of significant magnitude that nursing care will be affected. They further cited that the current shortage cuts across all health care delivery settings and all nursing practice areas (DHHS, 1988).

In psychiatric nursing the shortage is exceptionally serious. During the past few years the proportion of nurses entering the field of psychiatric nursing has declined drastically. There are many factors that have contributed to the nursing shortage in general and to the psychiatric nursing shortage in particular. There are but a few isolated programs in existence designed to alleviate the critical shortage in

psychiatric nursing. It was envisioned by Hospital Corporation of America (HCA) that a carefully designed training program in the form of clinical internships, could attract and retain nurses in this misunderstood field of nursing. A review of the literature on attracting nurses into the psychiatric field revealed that strategies such as increasing the pay for psychiatric nurses and shift adjustment did not result in the increase of qualified recruits. A search of the literature revealed that there is also little discussion of the use of nursing internships and even less on existing psychiatric educational programs of those who discuss the serious nursing shortage. This situation exists in spite of the call for innovative training programs that would help in the recruitment and retention of nurses in the psychiatric nursing area issued by the Federal Government through the Nursing Shortage Reduction Act of 1987 (Appendix A).

Purpose of the Study

The purpose of this study is to develop and evaluate a training curriculum in the form of an internship program intended to aid in the attraction of nurses into the field of psychiatric nursing. The evaluation of the internship program will take place at intervals beginning with the completion of the program, at six month and at one year.

Research Questions and Hypothesis

The following research questions were formulated:

1. Will the subjects in the internship training program (experimental) score significantly higher on selected evaluation instruments than their counterparts who did not received this training (comparison) but who have been in practice for a comparable time period?
2. Will the subjects in the internship training program (experimental) score significantly higher on selected evaluation instruments than their counterparts (comparison) who have not been processed through the training program?

The hypotheses formulated to answer question one on time series were as follows:

1. As measured by the instructor made exam, registered nurses in the internship program (experimental) will score significantly higher than registered nurses that did not receive internship training (comparison) at six months and at twelve months.
2. As measured by the National League for Nursing Psychiatric Nursing exam, professional registered nurses in the internship group (experimental) will score significantly higher than registered nurses that did not receive internship training

(comparison) of basic psychiatric mental health Knowledge at twelve months post-training as compared to their pre-training scores.

3. As measured by the National League for Nursing psychiatric Nursing exam, registered nurses in the internship group (experimental) will score significantly higher than registered nurses that did not receive internship training (comparison) on Assessment/Analysis at twelve months post-training as compared to their pre-training scores.

4. As measured by the National League for Nursing Psychiatric Nursing exam, registered nurses in the internship group (experimental) will score significantly higher than registered nurses that did not receive internship training (comparison) Evaluation at twelve months post-training as compared to their pre-training scores.

The hypotheses formulated to answer question two are as follows:

1. As measured by the instructor made exam, registered nurses in the internship group post-training (experimental) will score significantly higher than experienced psychiatric nurses who did not receive the training (comparison).

2. As measured by the National League for Nursing Psychiatric Nursing exam, professional registered nurses in the internship group post-training (experimental) will score significantly higher than experienced psychiatric nurses who did

not receive the training (comparison) on basic psychiatric mental health Knowledge.

3. As measured by the National League for Nursing Psychiatric Nursing exam, professional registered nurses in the internship group post-training (experimental) will score significantly higher than experienced psychiatric nurses who did not receive the training (comparison) on Assessment/Analysis.

4. As measured by the National League for Nursing Psychiatric Nursing exam, professional registered nurses in the internship group post-training (experimental) will score significantly higher than experienced psychiatric nurses who did not receive the training (comparison) on Evaluation.

Definition of Terms

Comparison group: Experienced psychiatric nurses who did not receive the internship training.

Experimental group: Professional registered nurses who received the internship training.

Effective nursing care: As measured by both the National League for Nursing exam in psychiatric Mental Health and the Instructor prepared exam.

Experienced registered nurse: One who is licensed by the state and has worked in the psychiatric nursing setting for more than one year.

Internship Program: A six-week prepared, comprehensive program of study in psychiatric nursing. The program involves

two weeks of didactic lecture and four weeks of supervised clinical training and practice

Instructor Made Exam: A test consisting of one hundred and sixty-four questions designed to evaluate the effectiveness of the didactic proportion of the internship component prepared by faculty at Florida International University.

Internship Student: A registered nurse sponsored by one of the four HCA Hospitals that participated in the six-week intensive comprehensive educational program.

National League for Nursing Psychiatric Exam: A test of one hundred and ten questions designed to assess behavior and apply therapeutic psychosocial interventions which was prepared and tested for validity and reliability by the National League for Nursing (NLN).

Registered Nurse: One who has formally completed a course of study, has taken the state licensing exam and has successfully passed the exam to become a registered nurse.

Significance of the study:

The recruitment and retention of professionals is often addressed through the development of educational efforts which are designed to engage the minds and spirits of professionals so as to bond them more closely to a particular aspect of work through the development of new knowledge and increased appreciation. This study is significant as it evaluates the effectiveness of an internship program as a strategy for

addressing the problem of recruitment and retention of psychiatric nurses in a hospital setting. As a model this curriculum may serve to guide others in planning professional programs with similar goals and objectives.

Limitations:

The limitations of the study include the following:

1. Because the control group in this evaluation were drawn directly from a small on-site labor pool, no claims are made with regard to external validity. Thus generalizability may be limited.

2. The economic constraints of the "real world" prevented the development of an ideal research setting in which a pre test could have been administered to the experimental group, and the instructor made exam and National League for Nursing Psychiatric exam could have been administered at nine months. In addition, an ideal condition would have been to administer the National League for Nursing Psychiatric exam at six month.

3. Neither the ethnicity nor the race of the students was considered.

4. The age of the students was not considered.

5. The gender of the students was not considered.

Assumptions

It was assumed that:

1. The internship student and the registered nurses have

the ability to take tests.

2. The participants of the internship program have the ability to learn.

3. HCA hospital staff are not unique but represent typical psychiatric personnel.

4. HCA represents a typical psychiatric hospital, and the internship applicants in the sample are indicative of the sample.

5. Content mastery positively impacts upon the quality of performance of professions.

6. Content mastery correlates with retention.

Chapter 2

Literature Review

The Nursing Shortage:

This review represents the rationale for the development of the internship training program that was presented, discussed and analyzed.

To understand the shortage of psychiatric nursing the overall nursing shortage now existing in the United States must be reviewed.

According to the Florida Nursing News (August, 1988) the shortage of nurses is so severe that it is reaching crisis proportions that threaten the quality of health care.

The American Hospital Association reported that the vacancy rate for registered nurses has more than doubled between 1985 and 1986 (Kennedy and Griffith, 1987).

In 1988, the Secretary's Commission on Nursing Reported that the shortage of registered nurses in all areas of patient care was evident. The registered nurses' vacancy rates had more than doubled between 1983 and 1987 from 4.4 percent to 11.3 percent. The report continued that while seventy-six percent of all hospitals reported at least some degree of shortage, nineteen percent reported shortages they considered as severe. This severe shortage caused greater proportions of

hospitals to resort to using "agency" nurses. (Agency nurses are those nurses contracted as needed through an outside business on a day-to-day basis when needed) In 1987, forty-seven percent of community hospitals reported using agency nurses. This use was an increase, up from thirty percent in 1986.

Hospitals, in both rural and urban areas, have been greatly impacted by the current nurse shortage. The Secretary's Commission report (1988) suggested however, that larger hospitals, and hospitals in urban areas, face the most serious problems.

The inability of hospitals to fill vacant positions has resulted in the closing of hospital beds. Thirty percent of hospitals in urban areas, and fifteen percent of rural hospitals have reported that they were forced to close beds temporarily in 1987 due to the nurse shortage (DHHS, 1988).

The reasons for the shortage of practicing nurses were many and complex. Perhaps the most significant effect on the health care system was the implementation, in 1984, of the Medicare Prospective Payment System (PPS). Under this system hospitals were paid preestablished fees for each medicare patient based on prior year's national averages for various diagnosis. This system eliminated the cost-based retrospective reimbursement system that had been paying for Medicare

beneficiaries' hospital care in the past. Medicare PPS was one of the many public and private cost containment initiatives introduced in the past decade (source).

Under the PPS system, strong incentives were established for hospitals to produce inpatient health care as efficiently as possible. In most cases hospitals sought to admit only those patients needing to be treated. Hospitals uncertain of the PPS effects on revenue that also desired to hold down expenses, turned to higher concentrations of registered nurses rather than relying on licensed professional nurses or nursing assistants and aids for a variety of reasons. First, there had been evidence that hospital nursing practice models relying on all registered nursing staffs had proven to be more effective (Burt, 1980). Second, nursing professional organizations had been actively promoting the registered nurse as the most effective nurse provider. Third, nurses helped promulgate the employer's belief that registered nurses could, and should, perform non-nursing duties on top of their regular patient care responsibilities. These non-nursing duties included such tasks as helping to clean patients room and paper work that could be completed by secretaries. In order to increase the demand for total nursing services, additional patient days of a higher severity than those eliminated (through reduced admission and shorter length of stay) were added. Thus, since the onset of

PPS more severely ill patients were being admitted in place of less severely ill patients. The less severely ill were referred to other treatment settings.

The need for more nurses resulted from other causes. The causes included increases in the aging population, the spread of the AIDS epidemic, and advances in medical technology.

As a group, the elderly consume a disproportionate amount of hospital services including nursing care. In fact, although the elderly represent only twelve percent of the population, they account for thirty percent of hospital discharges and forty-one percent of hospital days. Furthermore, the growing number of elderly receive more hospital inpatient care, than ever before. In 1987, there were approximately four million more Americans over the age of sixty-five (a total of thirty million) than in 1980 (U.S. Bureau of the Census, 1988). While the average discharge rate for the total population decreased nineteen percent from 1981 to 1986, the average hospital discharge rate for the over sixty-five population decreased only by thirteen percent. In addition, the discharge rate for those over seventy-five increased only four percent over this same period (NCHS, 1988).

The amount of hospital care provided to persons with Acquired Immune Deficiency Syndrome (AIDS) is substantial. A 1986 study, based on the first 10,000 AIDS cases, estimated

that persons with AIDS will spend an average of 168 days in the hospital during their lifetime (Hardy, et al., 1986). In fact, persons with AIDS have been shown to average 3.2 hospitalizations per year (Scitovsky and Rice, 1987). A recent study, based on 1985 survey data, estimated that an average person with AIDS spends thirty-two days per year in the hospital (Andrulis, et al., 1988). As of June 27, 1988, 28,585 individuals meeting the Center for Disease Control criteria for an AIDS diagnosis were living in the United States (CDC, 1988). Those persons with AIDS require exceptionally intensive nursing services (Fox, 1988). In addition, the spread of AIDS epidemic has undoubtedly frightened many nurses who work in close contact with these patients to the point that they have left nursing.

Advances in medical technology also impact on the nursing shortage. Improved technologies have increased life expectancy as well as the probability of survival beyond the first year of life. However, as medical technology improves and diagnostic capabilities prolong the life of hospitalized patients, it is also increasing these patients' needs for nursing services. Advances in technology require more registered nurses to manage the technological equipment and the severe side effects and complications of technological care. In addition, registered nurses must educate and provide

emotional support to anxious families (NLN, 1988) (D. Loper, National Association of Neonatal Nurses. Testimony before The Commission, San Francisco, CA, March 24, 1988).

Thus, there is no doubt that the reported shortage of registered nurses is real, widespread, and of significant magnitude and the current shortage cuts across all health care delivery setting and all nursing practice areas.

Enrollments in Nursing Programs

In past years, hospitals relied on a steady stream of new graduate nurses to fill existing vacancies. These hospitals are no longer able to do this because there is a decline in admissions, enrollments and graduations to schools of nursing.

According to a recent survey by Green (1987), the proportion of freshmen women in two and four year institutions interested in nursing careers has fallen by more than half, from 8.4 percent in 1983 to 4.1 percent in 1987. Also, a longitudinal study revealed that over half of the freshmen women in four year institutions who entered college in 1982 planning to pursue nursing as a profession changed professions during their undergraduate years. These students outnumbered women who decided to enter the field of nursing (Green, 1987). Declining enrollments in basic nursing programs is a recent occurrence and is a factor which distinguishes the current

nurse shortage from past shortages.

Total registered nurse enrollment peaked at 250,553 students in 1983. In 1985, total enrollments had decreased by thirteen percent. An eight percent decrease occurred between 1984 and 1985., and a five percent decrease occurred between 1985 and 1986. In 1987, enrollments continued to decline by more than 37,500 students or fifteen percent (NLN, 1987) (Kennedy and Griffith, 1987). Over the past twenty-two years, the greatest decrease in enrollments has been hospital based in diploma education. During which time the number of programs has decreased by about three percent each year. In 1961, enrollments in diploma programs numbered 95,983. By 1971, enrollments had dropped by twenty-six percent to 70,990. Between 1971 and 1981, they fell 42.2 percent to 41,009. In the past two years, however, diploma graduations have dropped to 30,000 which represents 26.4 percent decrease during the past five years. In the fall of 1985 alone, enrollments fell nineteen percent. That year, of the thirty six states with diploma programs, thirty four reported declines. The average enrollment per program dropped by twenty-six students (Gothler, 1987). Male enrollment in basic nursing education programs has also been declining since its apex in 1984. Associate degree programs revealed a decrease at seventeen percent, and baccalaureate programs demonstrated a sixty-one percent

decrease (NLN, 1987).

Astin (1987) anticipates a continuing decrease in the number of nursing graduates as a direct result of declines in enrollments in nursing education programs. Baccalaureate program graduations peaked in 1979, when 363 programs graduated 25,048 students. From 1979 to 1984, these programs reported about three percent decrease in graduations each year despite an increase in the number of basic baccalaureate programs; however, the number of basic baccalaureate graduates in 1985 did increase by five percent (Gothler, 1987). In 1987, graduations from nursing programs declined by 9,000 (eleven percent) from a historic peak in 1985.

The decline in the number of nurses will continue. This is in part due to the variety of opportunities open to women today that were closed a decade before. Educated women are able to now choose from fields such as business, engineering, dental school, medical school, law school and computer analyses. In fact, by 1990, it is estimated that American colleges are likely to award more medical doctorates than baccalaureate degrees in nursing (Green, 1988). This will greatly hinder the nurse population which is approximately ninety-seven percent women.

The salaries of nurses is also a major deterrent to pursuing a career in nursing. A 1987 survey indicates that

"being very well off financially" is one of the top personal goals of college freshmen (Astin et al., 1987). The starting salary for a nurse is approximately \$21,000. Although this is comparable to those of other professions, there is a wage compression or lack of growth opportunities for the registered nurse. According to Aiken and Mullinix (1987) registered nurse wages increased by four percent in 1986 while salaries of other female professionals increased by approximately ten percent.

The mass media further compromises the nurse's image by portraying the nurse in a demeaning manner. The nurse is often viewed as a "dumb blonde in high heels yielding to the mighty doctor." Although nurses are often the primary care-giver, the nurse-patient relationship is viewed as one that is controlled by physicians (Adelotte, 1987, Donaho, 1986, Kalesch and Kalesch, 1983). As a consequence, nursing is not viewed as important by the general public and, more importantly, potential applicants, do not view nursing as a profession of high value and social prestige.

As a result of the negative attitudes surrounding the nursing profession, less academically prepared students are choosing to enter the profession. In fact, students presently interested in pursuing nursing as a career are no longer the high achievers, as measured by formal examinations, as they were in years passed. College board data (1986) indicate that,

although the performance of all students on SAT's was generally improving, aspiring nurses' scores are declining (Green, 1987). Further evidence of the erosion of academically-able students has been reported from freshmen survey data on grade point averages (Green, 1987). These data indicate that a larger proportion of aspiring nurses (almost one-third) have a C or C+ grade point average than did non-nursing aspirants. Students' statistical aptitude test scores and grade point averages have proven to be two strong predictors of retention in college (Astin, 1987) (Rush and Belock, 1987).

In order to try to increase the number of nursing students, new programs are being started. As a result of the shortage new programs are often times funded by extended grants and there is careless recruitment of students and faculty. These programs have little or no analyses of their mission and yet forge headlong into nursing education. Many of the programs are shortened in efforts to attract more graduates. Hipps (1981) asserts that by starting new programs and shortening programs, the standards and status of nursing is lowered. In addition, the results of one study indicate that shrinking applicant pools are inducing some programs to lower admission standards and to offer remedial courses to the students they accept (Rosenberg, 1987).

Need For Psychiatric Nurses

Psychiatry has not been subject to the limits and demands of PPS and DRGS. Hospital and clinics are rapidly opening up floors and units to treat patients that exhibit emotional problems. This upsurge of psychiatric settings has come at an ideal time for patients, as there is a growing number of people that can benefit from psychiatric consultation. In 1979, Pisarcik reported that ten percent of the patients seen in Boston City Hospital Emergency Department had a psychiatric problem. By 1983, it was estimated that over thirty percent of the patients seen in emergency rooms could benefit from some type of psychiatric intervention (1979).

The American Psychiatric Association has defined a psychiatric emergency as "a situation that includes an acute disturbance of thought, behavior, mood or social relationships which requires immediate intervention as defined by the patient or family or social unit " (Merker, 1986, p. 5). Fauman and Fauman (1981) elaborated on this definition, stating that a "psychiatric emergency is an alteration in behavior, mood, or thought which the patient, a friend, relative or professional feels requires immediate medical attention. A psychiatric emergency is a crisis in a person's life which makes him feel overwhelmed, either because circumstances are extreme, prolonged, or intense or because the person's capacities are

limited by age, intelligence, illness or emotional strength at that time" (p. 15).

The elaborated definition includes not only mental illnesses that require acute hospitalization such as schizophrenia, bipolar disease and major depression but addictive and anxiety disorders as well. The picture painted of those in the need of mental health sounds bleak and morbid. Thus, a negative climate exists in the minds of those who might consider the field of psychiatric nursing.

The most common addictive disorders treated today are drug and alcohol abuse, anorexia and bulimia and compulsive gambling. The anxiety disorders most treated today include phobias and obsessive-compulsive diseases.

Medicine's focus to psychiatric illness has coincided with the American peoples' obsession with mental health. In a recent survey by the Neilson Rating Company (1988), it was revealed that the most popular television programs are talk shows which focus on coping with emotional stressors. In addition, today there are more popular books being sold on living without stress and learning about mental disorders than in the past (Donahue, 1988).

There was also attention given towards the unfortunate consequences that mental illness has on social institutions, economic institutions and our political institutions.

For example:

1. According to Fink, Reiger and Shepard(1978) people with diagnosed psychiatric problems use more medical services than those without identified psychiatric problems (Fink, et al., 1967; Reiger, et al., 1978; Shepard, et al., 1966).

2. Women between eighteen and forty-four years of age who are utilizing psychiatric services of general medical care than those are not utilizing psychiatric services (Hankin and Shapiro, 1980).

3. People with identified mental disorders show a greater incapacity for work compared with those without psychiatric symptoms especially when somatic disorders are also present (Dumas,1983).

4. Mental disturbances seem to have a particularly marked' effect on the working capacity of women (Dumas, 1983).

5. Neurosis (Anxiety Disorders) and personality disorders are strongly associated with incapacity in work (Dumas, 1983).

The economic and political consequences lie in the fact that it is costly in terms of lost income and unhealthy lifestyles. Brenner (1973)found that there was an inverse relationship between the state of the economy and mental illness.

As people see more and more need for treatment of psychiatric/mental illness coupled with ultimate hospitalization, the impact on nurses and nursing service will increase. There was a substantial need for not only registered nurses but for specially educated psychiatric nurses to work with this population that has become more aware and more willing to be treated for psychiatric problems.

History of Psychiatric Nurses

The first course on mental illness was taught by Dr. Benjamin Rush in 1783. However, until 1882, psychiatric patients were cared for by wardens of a jail whose major task was to assure conformity to rules. Physical violence and mechanical restraints were frequently used (Martin, 1985).

Education for psychiatric nursing began formally in the United States in 1882 with the opening of McLean Hospital in Boston. By the end of the decade, there were more than thirty-five psychiatric programs located in hospitals. Nurses were trained in psychiatric hospitals solely for use as nurses at that institution.

In 1906, general hospitals merged with psychiatric hospital schools. Psychiatric nursing began to be a requisite for nursing education (Martin, 1985). However, in 1920, MacMillian Company published the first psychiatric nursing textbook, Harriet Bailey's Nursing Mental Disease. The book

focused on the physical care of the mentally ill (Martin, 1985).

The National Mental Health Act of 1946 provided federal training funds to undergraduate programs of nursing to integrate mental health concepts throughout the curriculum. Also graduate programs in psychiatric nursing were established (NMHA, 1946).

As the 1950's came to a close, significant changes in psychiatric-mental health nursing emerged, primarily as a result of the National Mental Health Act which was the forerunner of the National Institute of Mental Health (NIMH). These changes were:

1. Lengthening Master's degree programs from one year to one and one-half or two years
2. Increase theoretical and scientific content base from the social and behavioral sciences
3. Increase in psychoanalytical theory, its clarification, modification and adaption to nursing
4. Introducing psychiatric-mental health and behavioral concepts into the collegiate undergraduate curricula
5. Introduction of the Master's degree prepared psychiatric-mental health specialist (Chamberlain, 1983)

In 1963, President John F. Kennedy told Congress of his deep and sincere concern for the problems of mental health. He

called for a "bold new approach." As a result of his speech, Congress passed the Community Mental Health Center's Act which authorized funds for the development of comprehensive community mental health centers (Chamberlain, 1983).

The budget for psychiatric nursing education programs peaked in 1969 with an annual budget of approximately twelve million dollars with the award of 1,721 stipends annually at both the undergraduate and graduate levels of study (Chamberlain, 1983).

The 1970's brought forth the deinstitutionalization of psychiatric patients. These judgments centered around the patients' rights to treatment and the right to the least restrictive conditions necessary to achieve this plan of care (Carter, 1986).

The psychiatric nursing field was considered the most innovative field in nursing. Faculty from the psychiatric nursing schools were strong and respected. Publications of psychiatric nurses outnumbered any other specialty area. Almost all of the reputable undergraduate programs in nursing had faculty to integrate behavioral science concepts in the curriculum, and every curriculum included at least one course labeled psychiatric nursing. Psychiatric nurses provided outstanding leadership in advancing nursing theory through their scholarship and theoretical formulations of psychiatric

nursing practice, and through their pioneering research. Psychiatric nurses were sought to fill deanships and other high ranking positions in professional organizations and federal agencies. Just two decades ago this field was considered avant-garde; on the cutting edge of change in nursing and in the community mental health movement (Pumas, 1983).

Dumas (1983) contends that the excitement, the intellectual ferment and the progress that was evident during those times are no longer apparent. The rigorous efforts to develop psychiatric nursing theory and innovative approaches have subsided.

During the past few years, the proportion of nurses entering the mental health field, even compared with other fields of nursing, has been decreasing (Chamberlain, 1983). The reasons for the lack of interest in psychiatric nursing are complex and varied.

Shortage of Psychiatric Nurses.

In a survey conducted by Mitsunaga, Lowery, Banchik and Miller(1982) only five percent of the respondents to a survey conducted at a generic bachelors degree in nursing (BSN) program in Colorado chose psychiatric nursing as their preferred practice field. (Mitsunaga, 1982). Also, from 1968 to 1988, there was a marked decline in the enrollment of nurses in the psychiatric mental health nursing Master's program in

contrast to other specialities.

Factors cited for the declining interest in psychiatric nursing include financial, political and social, and professional changes.

Federal monies for mental health began to decrease in the early 1970's. The budget hit an all time low of 7.5 million dollars in 1973. In that period most of the undergraduate mental health nursing integration projects were phased out (Chamberlain, 1983). Cutbacks in government funding had reduced the abilities of psychiatric facilities to deliver services. However, at the same time, the need for services was increasing. Deteriorating socioeconomic conditions, population growth, and social mobility were among the factors contributing to the rising levels of stress (Mitsunaga, 1982).

A limited budget in higher education was also causing faculty to decrease and student enrollment to decline (Mitsunaga, 1982).

Psychiatric nursing as a discipline derives its base from communication theory, systems theory, family dynamic and group theory. Many of the functions of the psychiatric nurse were also performed by the psychiatrist, psychologist, social worker, occupational and recreational therapist, the milieu counselor and spiritual advisor. The psychiatric nurse's role was emphasized to be an interchangeable and diverse member of

the health team. Unfortunately, this also led to psychiatric nurses overly identifying with other mental health care professionals. In fact some psychiatric nurses who began a liaison with other workers became regarded as outsiders (McBride, 1986).

It was also not quite clear what the psychiatric nurse did. The expanded role of the psychiatric nurse allowed for the practice of the individual, group and family therapy as well as being eligible to apply for the status of the advanced registered nurse practitioner and clinical specialist. While this freedom fostered creativity and growth, it further blurred the image of the psychiatric nurse (Kalish, 1983). According to Fagin (1985), the only role of the psychiatric nurse that differentiated the nurse's function was the administration of medications.

There was also a lot of confusion related to the name used to describe the discipline itself. Was it psychiatric nursing, psychiatric mental health nursing, psycho-social nursing or some other speciality (McBride, 1986).

The integrated curriculum has also been frequently cited as a source of problems for the field of psychiatric nursing (Arnsward, Chamberlain, Dumas, Mitsunaga, Noonan, 1987). For the last fifteen to twenty-five years, the integrated curriculum has been the prevailing model used in nursing

schools. Under the integrated model, concepts and knowledge unique to nursing were identified, structured and blended to form the courses of the curriculum (Hipps, 1981). The concern with the integrated model was that, many nursing schools have lost the psychiatric nursing course.

Psychiatric-mental health nursing was also frequently the victim of an academic strategy to compress or accelerate nursing education. According to Robinson (1986) when this speciality is subsumed under another category of study, it was assumed that nursing students will learn to relate to patients with other diseases and that they would be able to transfer these skills to the real psychiatric patient. Such students may never understand the roles and functions of patients and staff in a psychiatric setting(1986).

Furthermore, the integrated curriculum stressed the role of the nurse as a generalist. Many of the faculty from other disciplines were lead to believe that they could teach psychiatric nursing. This resulted in faculty that did not have a firm grasp on the principles and concepts of the discipline (Carter, 1986).

Wahl (1984), in his summary report of the conferences "Psychiatric Mental Health Nursing before the year 2001," stated that many psychiatric nurses are publishing in journals other then psychiatric nursing such as maternal and child

health. This phenomena has led to diminishing research in the field of psychiatric nursing.

Another factor that has affected the supply of psychiatric nurses was the deinstitutionalization of patients. This action in concert with other political movements, paved the way for mentally ill patients being placed on the streets without a community to absorb them. Untreated and unserved mental patients, stigmatized and victimized, hopeless and homeless, seem to be an ever present visible evidence of the failure of the professional psychiatric community (Carter, 1986).

The majority of nurses prepared in the psychiatric mental health setting do not choose to work with the "street people." Mitsunaga (1982) was concerned about the limitations she sees in the preparation of nurses for service in the mental health system. Although well-prepared to treat "YAWVISS" (young attractive, verbal, intelligent, sophisticated and sexy) patients; they were unable to provide necessary services to the rural and chronically mentally ill patient who were no longer institutionalized.

According to Kiesleer and Sibulkin (1984), the hospitalization rate for the chronically mentally ill patient has steadily increased from 1965-1969 .

Developmental Education

In-service or institutional developmental programs were

used to upgrade or increase the knowledge base of the psychiatric nurse. These programs were designed to aid the nurse to be a more effective giver of care which would ultimately lead to retention.

The adverse effects of turnover and shortage are hazardous to the hospital trying to maintain quality of care while decreasing costs. Institutions needed assurance that the quality of care was competitive. Satisfaction with health care was an important factor for attracting patients, physicians, and third party payers to a particular health care institution (Hinshaw, 1987).

According to a study conducted on staff developmental evaluation by Haggarety and Abraham (1983) the success of a staff developmental program was a function of, at first, how employees perceived the effects of the program on their clinical work; and second, how employees perceived the structural-administrative reasons for their participation in the programs. Their study attests to the exigency on the part of educators to provide highly individualized learning experiences. Indeed fulfilling the learning needs and expectations of staff is important, yet nursing staff had a need for clinical supervision and administrative support as well. If a staff development program is to be successful, the purposes and functions of the program should be clearly

delineated. Nurse educators should prescribe in-service education coupled with individualized clinical supervision and administrative support (Haggary and Abraham, 1983).

Critchley (1987) described clinical supervision as an experience that assists the nurse to sort out the impact of staff dynamics on students self-awareness and perception of the patient-therapist relationship. In addition, stated Critchley, clinical supervision is helpful in sensitizing nurses to deal with the complex therapeutic issues as well as learn the skills of psychotherapy.

The creation of in-service programs was considered an innovative strategy used to combat the shortage of nurses and the turnover of nursing staff. In-service programs fostered renewed enthusiasm for the field, and demonstrated to the nurses that administrators cared about their professional growth and development (Hinshaw, 1987).

Educational Conceptual Model

Psychiatric nursing is a technical yet professional discipline. As with all professions, it requires that the nurse have a firm grasp on the theoretical foundations of psychiatry as well as the ability to apply appropriate therapeutic intervention skills. In addition to conceptualizing knowledge and learning techniques, psychiatric nursing, also mandates that the nurse have insight into his/her own behavior and a

sense of interpersonal ease with patients and clients.

Tyler (1952) listed two distinctive attributes of a true profession: a recognized code of ethics and techniques of operation based upon principles rather than a rule of thumb or simple routine procedures.

Taba (1962) adapted Tyler's model through a seven-step process. These steps were: 1) Diagnosis of needs; 2) Formulation of objectives; 3) Selection of content; 4) Organization of content; 5) Selection of learning experiences; 6) Organization of learning experiences; and, 7) Determination of what to evaluate and of the ways and means of doing it.

Planners and developers in professional education differ in their conceptions concerning the form and content of curriculum. Curriculum theorists who adhere to the subject/matter discipline designs assume there is a basic body of knowledge that constitutes the curriculum. Proponents of the subject matter/disciplines argue that knowledge is of necessity at the base of the curriculum (Eisner and Vallance, 1974). A course in psychiatric nursing, therefore could center on the principles and premises of the field. However, In a field as dynamic as health and nursing, the half life of knowledge was approximately five years (Mayhew, 1971).

Bobbit (1924) called for a curriculum design focused on

specific competencies or technology. Bobbit proposed that the curriculum aim at objectives not attained by undirected training and that "the curriculum of the directed training be discovered in the shortcomings to individuals after they have had all that can be done in the undirected training (Mayhew, 1971).

Palmer (1974) advocated that curriculum theorists in professional education should design curriculums that were pure, empirical, pragmatic and marketable. A course in psychiatric nursing that used this technology framework would focus on teaching required skills by performance criteria.

Realistically, the goal of professional education was to prepare more than highly skilled technicians or content specialists. Israel Scheffler (1965) stated:

the doctor, the researcher, the lawyer, and the teacher are not simply persons who have acquired technical facilities which can be run off automatically; they need competencies which require the continual exercise of strategic judgment concerning individual cases which they have never confronted before and for which there are no exhaustive rules dictating decisions to be made. Professional education must provide opportunities for the genuine exercise of students' judgment, as well as for critical reflection on the outcomes and strategic principles of such judgment (p. 25).

Agyris and Schon (1974) declared that professional schools today live in frustration between theory and practice. In fact, it has become a cliché to say that professionals must relate

knowledge to effective action, or integrate theory and practice.

The foundation for future professional competence seems to be the capacity to learn how to learn. This requires developing one's own continuing theory of practice under real conditions.

Agyris and Schon (1974) also examined the issue of practitioner-client relations. They were concerned with the question of how might professional education be redesigned to foster greater competence and effectiveness in practitioner-client therapeutic relationship. They address the issues in three ways. First, they develop two alternative models of behavior that may govern a practitioner's relations with clients and discussed the consequences of those models. Second, Agyris and Schon describe in detail the development and content of a seminar designed to enhance the use of a facilitative model of professional behavior. Lastly, they discussed in more general terms the redesign of professional education.

In order to clearly understand the work of Agyris and Schon it was important to identify the distinction they drew between theories of action and theories of use. Theories of action were espoused theories that professionals report as the concepts governing their interpersonal behavior.

Theories-in-use were the apparent constraints inferred from their actual behavior. Agyris and Schon maintain that discrepancies often existed between espoused theories and theories-in-use.

Agyris and Schon outline two models of behavior. Model I and Model II. They declared the predominant theory-in-use in our society, Model I, was based on four governing values. These four governing values were: 1) Achieve your own purpose as defined by yourself, 2) Win, do not lose, 3) Suppress negative feelings and 4) Be rational. These values however, could lead to action strategies of unilaterally designing and managing the environment, owning and controlling the task at hand, and protecting both oneself and others from being hurt. Individuals following such strategies were seen as closed and manipulative; interpersonal and group relations become highly defensive and commitment to actions and risk taking were low. Such consequences provide little opportunity for new learning, and, in fact, reinforce the governing values of Model I.

A second theory-in-use, Model II, offers the potential for greater learning and more effective interpersonal relations. The governing values for this model were; maximize valid information, maximize freedom of choice, enhance internal commitment to choices made, and monitor consequences of these decisions.

Agyris and Schon hypothesize that internalizing Model II as a theory-in-use should result in greater learning and professional effectiveness.

Educational programs using Model II ideas, would involve an innovative combination of conceptual inputs, creative use of case materials, and process learning from here and now experiences. Model I emphasized that the individual be as articulate as possible about objectives, goals and purposes and simultaneously control the others and the environment in order to assure that his/her purposes could be obtained. Model II does not reject the skill or competence needed to be articulate and precise about one's purposes. It does reject unilateral control over others as a way to achieve the purposes and to win in advisory relationships. Model II coupled articulateness and advocacy with an invitation to confront one's views, to alter them, in order to produce the position that was based on the most complete, valid information possible, to which people involved can become internally committed. This means that the participant in Model II behavior, was skilled at inviting a kind of learning called double-loop learning. Double-loop learning was distinguished from single loop learning. In single-loop learning, the field of constancy was maintained by designing actions that tend to satisfy existing governing variables. An example of this was to suppress conflict. In

double-loop learning the field of constancy is changed itself. Thereby, one would not simply learn to block conflict, but would learn to deal with the surfacing and resolution of such feelings.

Every significant Model II action was evaluated in terms of the degree it helped the individuals involved generate valid and useful information, solve the problem in such a way that it remained solved, and do so without reducing the present level of problem-solving effectiveness.

The behavioral strategies of Model II necessitated the sharing of power with anyone who had the competence and who were relevant in deciding or implementing the action. Individuals in a Model II setting seek to build viable decision-making networks in which one of the most important functions of the group is to maximize the contributions of each member so that when a synthesis was developed, the widest possible exploration of views has occurred. Evaluations, judgments and attributions were minimized so that they could be confronted openly and constructively.

If the governing values and behavioral strategies were used, then the degree of defensiveness within individuals, within groups, and between and among groups would tend to decrease. Free choice will tend to increase as would feelings of internal commitment and essentiality.

In summary, Model II is a conceptual approach that provides for an open system. Feedback is utilized to enhance growth and development. A Model I approach does not offer the same feedback loop, thus information, however faulty, can be recycled.

Chapter 3

Methodology

The psychiatric nurse internship program, was a proactive effort to address and manage the growing nursing shortage that impacted on the HCA facilities in Houston, Texas. The program, was designed to attract and retain nurses to employment opportunities in the four hospitals, using both clinical and didactic components. During the six-week internship program, a comprehensive introduction to psychiatric nursing was provided and upon completion of the program, nurses were prepared with new skills to care for psychiatric patients.

The internship program's target market included graduate nurses who wished to return to work but who required orientation. It also included nurses educated in other specialities who wished to change or enhance their career paths by working in mental health.

Program Objectives

The psychiatric nurse internship program was designed to:

1. Provide high quality nursing care to psychiatric clients.
2. Retain nurses in the area of psychiatric nursing.
3. Attract nurses to the area of psychiatric nursing

Development of the Curriculum

The six week internship program was planned, developed, implemented and evaluated to prepare the registered nurse who desired to function in the role of a professional psychiatric mental health nurse.

All educators think about ways of getting their body of knowledge across to learners. Nursing educators, along with other educators in the professional and practice disciplines, have the added task of transmitting a body of knowledge that has, as its ultimate aim, the provision of a frame of reference, that can meet a particular need of society.

Tyler (1952) described a true profession as one which contains: a recognized code of ethics and techniques of operation based upon principles.

A literature review of nursing reveals three recurrent themes that represent the essence or ethics of professional nursing (Donaldson and Crowley, 1978):

1. Concern with principles and laws governing life processes and the optimal functioning of all persons, sick or well. This concern is expressed through primary and secondary prevention measures and through tertiary prevention programs used to reduce residual disability.

2. Concern with patterned interactions between

individuals and their external environment in critical life situations.

This concern is demonstrated in the maintenance of a therapeutic environment and the reinforcement of clients' adaptive coping skills and behavior.

3. Concern with support systems and interpersonal process that promote functional adaptation in individuals, families, and communities. This concern is reflected in the interpersonal transactions between nurses and clients, in the self-monitoring and self-utilization of family and community resources (page, 14).

The themes above constituted the frame for the curriculum which governed the plan for the psychiatric internship program. The completed framework, as defined by Taba, included the educational model, the diagnosis of needs, formulation of objectives, selection of content, organization of content, selection of learning experiences, organization of learning experiences and an evaluation.

Agyris and Schons' Model II was the educational framework used to design the curriculum. As a theory in practice, Model II integrates knowledge and practice into professional effectiveness. It is through the application of the principles of Model II that the internships' practical experiences were derived.

When knowledge was perceived as one of the main concerns in the design of a curriculum, the faculty was declaring that

psychiatric nursing has a unique body of knowledge and a method of inquiry that could be taught so that nurses were prepared to continue to learn for their professional lifetime.

Practice in nursing involved the use of a clinical setting that offered the nurse an opportunity to practice the kind of behavior implied in the behavioral objectives. The main goal of the clinical experience was to learn to become more reflective under real time conditions so that ad hoc theories of action could be created and tested. Ideally, the supervisors (clinical instructors) should have been trained by the didactic instructors to maximize their potential so use of "Model II" techniques would have been more consistent and effective. However, the economic constraints of money and time did not allow this to be feasible. The supervisors of the clinical area were chosen by the Director of HCA. The qualifications for the position included a license to practice registered nursing, and a Masters in Psychiatric Nursing, with at least two years of experience in teaching. The Director and Didactic instructor believed, that the skills required to learn psychiatric nursing (empathy, ability to confront, realness and honesty) are those same qualities needed of the supervisors in the Model II approach.

According to Agyris and Schons' Model II approach the behavioral strategies of "Model II" involved sharing power with anyone who has competence and who is relevant in deciding or

implementing the action. Under Model II conditions, as new concepts were learned the meaning given to them and the inference processes used to develop them were open to scrutiny. Evaluations and attributions were minimized. The professor assumes the responsibility to present the evaluations and attributions in ways that encouraged that they would be confronted openly and constructively. The result of this was an environment of high authenticity and enlarged freedom of choice where action could become more effective. In effect this was double loop learning where the basic assumptions behind ideas or present views were confronted, where hypotheses were tested publicly, and where the processes were disconfirmable. Again the emergence of a compelling rationale for an internship or clinical experience becomes obvious.

In defining clinical experiences, many of the functions illustrated in Agyris and Schons' Model II theory are be employed. These functions were:

Gap-filling, translation, internalization: The task is to help the students related preprogrammed applied theories to concrete situations of practice, which means (1) learning to fill the information gap between theory and practice, (2) learning to translate verbal learnings in which information is conveyed through interactions with others, and (3) learning to internalize complex programs so that they can be carried out smoothly and effectively. The clinical experience allowed the nurse intern to attend medical and nursing rounds with their supervisor and staff at the hospital. Rounds,

allowed the nurse intern the opportunity to model the tasks to be undertaken and observe the structure and sequence of the tasks.

Theory-building: diagnosis: The task is to teach antecedent skills such as observation, listening, and entering new settings.

The clinical experience consisted of four weeks in a hospital in which the nurse intern was immersed in the system. Risks and pressures were low. Supervision consisted of debriefing the student; questioning him/her about aspects of the hospital he/she may not have noticed; modeling the kinds of listening, observing and interviewing that is necessary in a psychiatric nurse role and encouraging the nurse intern to build a hypothesis account for puzzling phenomena.

Theory-building: testing. The function of this task is to test hypothesis. The psychiatric nurse intern was assigned clients to treat therapeutically. The supervisor was consistently available to offer feedback to the intern and identify how intervention strategies in the real setting are different from those applicable to case studies in the text book.

Theory-building: personal causality. In this situation students are to care for the client and negotiate his performance with the client. The task is characterized by high risk, pressures, deadlines and accountability. This was carried out via the nursing care plan which consists of the client signing the care plan. The objectives of the psychiatric nurse internship program were clear, precise and relevant statements that were compatible with the conceptual model and relevant to the content. The selection of content, the organization of content, the selection of learning experiences, the organization of learning experiences and evaluation can be found in Appendix (Curriculum).

In preparing the curriculum, Model II functions were employed as "learning experiences" that coincided with the objectives, content and evaluation of the didactic component. Model II activities bridged the gap between theory and practice.

Subjects

The interns constituted individuals recently graduated nurses who required orientation, and registered nurses educated in other specialties who wished to enhance their career paths by working in the mental health field.

The population was recruited through local newspapers in the greater Houston area. All who applied were screened for eligibility and mental stability by the Director of Nursing at each of the hospitals involved using a psycho-social mental status exam, this is a usual procedure for hiring potential employees. This procedure yielded a class of 23 psychiatric internship nurses.

An ongoing comparison was maintained comparing the 23 members of the internship class with 23 HCA staff nurses.

All subjects considered were registered nurses who were training for full-time positions in a variety of psychiatric settings. The mean age of the population was 35 years old.

The Implementation of the Curriculum Evaluation

Plan for Evaluation

The first group of nurses (experimental) were trained and tested in July of 1987 (N=23). In February of 1988, the experimental group were retested. In July of 1988, the experimental group was retested again. The retesting served as

an evaluative criteria. In July of 1988, 23 subjects were used as match controls (comparison). The comparison group were employed nurses at one of the four HCA psychiatric hospitals in the greater Houston area. Although they were not exposed to the internship program, many of the subjects in the comparison group had acquired considerable experience in the psychiatric setting. An attempt was made to match the experimental and comparison groups on psychiatric training months of experience and numbers of years of education in nursing. However, because the comparison group was drawn from the pool of psychiatric nurses working at one of the four HCA hospitals, there were not enough nurses to choose from with just one year of psychiatric experience. The reason for this is, had the nurses started working for HCA one year previously, they would have been a candidate for the internship training. Since no new nurses were hired after the interns completed the program (as the hospitals were adequately staffed) the nurses chosen as a "matched sample" had more than one year experience. This situation was cited as a limitation of the study. It should be further emphasized that as close a matched sample as was feasible from the pool was ascertained.

Procedure

The experimental group was instructed over the course of six-weeks. The didactic portion of the training consisted of

eight hours of classroom lectures. Forty hours (eight hour days, five days per week) of didactic was presented in week one. Week two and week three consisted of six hours, five days a week of supervised clinical training in one of the four HCA hospitals. Week four consisted of forty hours of didactic teaching for eight hours per day, five days a week. Week five and six were clinical days consisting of six hour days lasting ten days.

At the end of the six weeks, the experimental group was tested with the National League for Nursing Achievement test and the teacher made exam and then assigned to various psychiatric units within the sponsoring organization.

The experimental group was tested six months later using the National League for Nursing Achievement test. The experimental group was also tested twelve months later using National League for Nursing Achievement test and the teacher made test.

The comparison group of matched controls were tested with the National League for Nursing Achievement test and the teacher made test at the same time the experimental group was tested at twelve months. The instructor prepared instrument was based on the content of the repeated measure of analysis of variance.

Both the experimental and comparison groups filled out a basic information profile which is included in Appendix C. It asked the number of months experience they had in a psychiatric nursing setting, the number of years spent in a formal nursing

education setting, and the type of degree obtained from nursing school.

The selection of an appropriate design involved selecting the most valid experimental approach within the economic constraints posed by HCA. HCA could not afford to pay the experimental group to sit for a pre-testing. Nor could HCA afford to pay, in time and money, the experimental group to take the National League for Nursing Psychiatric exam at six months. Gay (1987) states that the experimental method was the only method of research that can truly test hypotheses concerning cause-and-effect relationships. One type of experimental design was the static-group comparison.

The static-group comparison involves at least two groups; one receives a new, or unusual, treatment and both groups are post-tested. The posttest scores of the two groups are then compared...The degree to which the groups are equivalent is the degree to which their comparison is reasonable. Since subjects are not randomly assigned to groups, and since there are no pretest data, however, it is difficult to determine just how equivalent they are. It is also possible that posttest differences are due to group differences, not just treatment effects such as maturation, selection and treatment interactions. Mortality is also a problem since if you lose subjects from the study you have no information concerning what you have lost (no pretest data) (Gay, 1981, page 133).

The time-series design is an elaboration of the one-group pretest posttest design.

One group is repeatedly posttested. If a group scores essentially the same on a number of pretest and then significantly

improves following a treatment, the researcher has more confidence in the effectiveness of the treatment than if just one pretest and one posttest was administered (Gay, 1981).

The present design incorporated both static group design comparing the experimental group (post-training with a control group on their performance) and a time series design on the experimental group, testing each at three points in time (post-training, six months and twelve months post-training).

Due to the reality of constraints previously described of time, moneys and work schedules of the sponsoring organization, a true experimental design utilizing random assignment of subjects to groups was not practical. This design was one of the compromises utilizing two quasi-experimental designs in an effort to compensate for the shortcomings of each.

Instrumentations

The instrument used to measure cognitive aptitude in psychiatric nursing was the National League for Nursing exam in Psychiatric Mental Health. The test assists users to evaluate the effectiveness with which they were meeting the objectives of similar educational programs as defined by representatives of those programs throughout the country.

The test of 110 questions was designed specifically to measure the student's ability to assess behavior and apply therapeutic psychosocial interventions. Situations were presented

which involve problematic patterns of behavior in individuals and families throughout the life cycle. The items focus on the application of principles of therapeutic communication and intervention in a wide variety of client situations. In addition to the major psychiatric disorders, the client situations include substance abuse, child abuse, situational crises and psychophysiological problems. The National League for Nursing testing service does not suggest "acceptable" scores. It was intended to compare the performance of students in a similar or not similar program.

The Decision score was based upon the examinee's total score. For the exam, it was a standard score for which the average score was 100 and the standard deviation was 20 for all examinees in the norm's group. Most of the scores have a range from 50-150. This score, therefore, ranges from 0-100.

Accompanying the Decision score was its Standard Error of Measurement (SEM). SEM is an index of variability in the student's score, and estimates the variability in scores that might be expected if the student were tested repeatedly. In practice, $\pm$ SEM around observed scores will contain the student's "true" score.

The Advisory Score records the percentage of items in a subscore which the students answered correctly. An advisory score was provided for each subscore in the examination. The test is

not intended to determine Pass/Fail status.

The National League for Nursing Achievement Test for Mental Health Nursing is a widely used and extremely reliable test. The reliability score for registered nurses having graduated from an Associate Degree Program is .85. The reliability score for registered nurses having graduated from a baccalaureate program is .83. The reliability score for a registered nurse that has graduated from a Diploma school is lower but still significant at .76.

The test generated a score report that yielded the following type of information:

- 1) Identification of the types of programs and the number of examinees on whose performance the norms were based.
- 2) Norms Period, which specifies the time during which those included in the norm groups were tested.
- 3) Code number for students named on the group or class report.

The teacher-made test, a second tool employed (Appendix D) has a specific value because it reflects course emphasis and can be tailor-made to reflect the specific objectives of the program. In addition, these tests can better serve to motivate students because they pertain more directly to particular course content and can therefore provide more reliable information about the strengths and weaknesses of students and teachers. Teacher-made

tests provide a basis for grades and feedback to the teacher information about the effectiveness of testing.

The teacher made test consists of 125 questions. It has face validity and has been used for four years by psychiatric professors who hold a doctorate degree.

Chapter 4

Results

Reporting Conclusions

This chapter will explain the results of the study and relate it to the research question and to the hypotheses formulated. The chapter is organized into Reporting Conclusions, Subject Variables, Effects of Training Pre and Post-Test Experimental Group, Instructor Made Test, NLN Instrument, Experimental vs Control Group Comparison and finally graphs and tables.

All analyses reported as non significant failed to yield statistical values that had an associated alpha level $< .05$. The subscript E and C will be used to denote statistics related to the experimental and comparison groups respectively. The symbols M and S will be used to indicate the sample means and standard deviation respectively. The numbers in parentheses following a statistical test indicate the degree of freedom for that particular analysis. All t-test probabilities reported are one tailed unless otherwise noted. F Ratios refer to both ANOVA and ANCOVAS. All figures and tables referred to in this section, unless otherwise noted, are located at the end of this chapter.

Subject Variables

Several analyses were conducted to test the homogeneity of

subjects between treatment groups. Analysis of variance was conducted to compare the experimental and comparison groups in regards to their years of nursing education.

This analysis failed to yield a significant difference between groups ($M_e=2.69$; $S_e=.75$; $M_c=2.65$; $S_c=.89$;) $F(1,37)=.02$).

An analysis of variance was conducted to compare the experimental and comparison groups on the age of subjects. This analysis failed to yield any significant difference between groups on this measure ($M_e=44.62$; $S_e=8.01$; $M_c=42.38$; $S_c=8.82$; $F(1,37)=.59$).

An analysis of variance conducted on the treatment group on years of psychiatric nursing experience yielded significant differences with the comparison group being clearly more experienced than the experimental group ($M_e=1.31$, $S_e=1.12$; $M_c=6.01$, $S_c=6.06$; $F(1,37)=7.60$, $p<.01$).

Mean group data on subject variables is reported in Table 1. ANOVA table for nursing experience is presented in Table 2

Effects of Training Pre and Post-Test Experimental Group

The first set of analyses to assess the effects of training focused on the experimental group comparing their performance post-training and at twelve months after instruction. The following research question was formulated: Will the subjects in the internship training program (experimental) score significantly higher on selected evaluation instruments than

their counterparts who have not

received this training (comparison) but who have been in practice for a comparable time period?

Instructor Made Test

A series of paired t tests comparing the experimental subjects performance on the instructor prepared tests at post-training, at six months and at twelve months time periods were conducted. On the dependent measure of the instructor made instrument the answer to the first hypothesis was: As measured by the instructor made exam, registered nurses in the internship program (experimental) will score significantly higher than registered nurses that did not receive internship training (comparison) at six months and at twelve months. The null hypothesis to this question was: There is no significant difference between the experimental groups performance and the comparison groups performance just after training and six months later. ($M_0=76.85, S_0=18.59; M_6=84.12, S_6=6.38, t_{\text{paired}}(12)=-1.40$). The null hypothesis was accepted.

No significant differences were found on the experimental and control groups performance between their initial testing and follow-up testing twelve months later. These results were found on the instructor made instrument ($m_0=77.42, S_0=18.58, M_{12}=75.06, S_{12}=7.13; t_{\text{paired}}(13)=.48$).

There was a significant decline in the experimental groups performance on the instructor made instrument between their performance at six months and twelve months ($m_6=84.11$, $S_6=6.38$; $M_{12}=74.69$, $S_{12}=7.00$ t paired $=(12)7.43$ $p<.001$).

Figure 1 shows the experimental performance on this measure over time.

NLN Instrument

A series of three paired t tests were conducted on the experimental subjects scores on the three sub scales of the NLN instrument comparing the time periods immediately after instruction and twelve months later. On the dependent measure on the National League of Nursing Psychiatric nursing exam, the answer to the second hypothesis was: As measured by the National League for Nursing Psychiatric Nursing exam, professional registered nurses in the internship group (experimental group) will score significantly higher than registered nurses that did not receive internship training (comparison) of basic psychiatric mental health Knowledge at twelve months post-training as compared to their pre-training scores. The null hypothesis to this question was: There was no differences found on subscale Knowledge immediately after training and twelve months later for the experimental subjects ($m_0=21.64$, $S_0=3.03$; $M_{12}=21.14$, $S_{12}=3.35$; t paired $(13)=.54$). The null hypothesis was accepted. On the dependent measure on the

National League for Nursing Psychiatric Nursing exam the answer to hypothesis three was: As measured by the National League for Nursing Psychiatric Nursing exam, registered nurses in the internship group (experimental) will score significantly higher than registered nurses that did not receive internship training (comparison) on Assessment/Analysis at twelve months post-training as compared to their pre-training scores. The null hypothesis to this question was: There was no significant differences found on subscale Assessment/Analysis immediately after training and twelve months later for the experimental subjects ($m_0=35.14$, $S_0=6.25$; $M_{12}=37$, $S_{12}=2.88$; $t_{\text{paired}}(13)=-1.33$. The null hypothesis to this question was accepted.

On the dependent measure of the National League for Nursing Psychiatric Nursing exam the answer to hypothesis four was: As measured by the National League for Nursing Psychiatric Nursing exam, registered nurses in the internship group (experimental) will score significantly higher than registered nurses that did not receive internship training (comparison) on Evaluation at twelve months post-training as compared to their pre-training scores. The null hypothesis to this question was: There was no significant differences found on subscale Evaluation immediately after training and twelve months later for the experimental subjects ($m_0=2.87$, $S_0=2.51$; $M_{12}=27.99$, $S_{12}=2.41$; $t_{\text{paired}}(13)=1.08$). The null hypothesis to this question was accepted.

Figure 2 shows the experimental groups performance on all the NLN measures.

Experimental vs Control Group Comparison

The next series of analyses compared the experimental and comparison groups on the dependent measures. The testing for the experimental group took place immediately after training and their performance was analyzed against an untrained comparison group of psychiatric nurses. Taking into account the differences between the groups on years of nursing experience, a decision was made to use analysis of covariance with experience as the covariate as the main statistical test for this group of analyses. The second research question was formulated: Will the subjects in the internship program (experimental) score significantly higher on selected evaluation instruments than their counterpart experienced registered nurses (comparison) who have not been processed through the training program?

On the dependent measure of the instructor made instrument the answer to hypothesis one was: As measured by the instructor made exam registered nurses in the internship group post-training (experimental) will score significantly higher than experienced psychiatric nurses who did not receive the training (comparison). The null hypothesis to this question

was: There was no significant difference found between the experimental and comparison groups regarding their level of performance (ME Adjusted =75.47, M_C adjusted =68.74; $F(1,34)=2.05$). The null hypothesis was accepted.

Table 3 presents the ANCOVA summary data. Figure 3 is a graph of the comparison.

On the dependent measure NLN subtest knowledge the answer to hypothesis two was: As measured by the National League for Nursing Psychiatric Nursing exam, professional registered nurses in the internship group post-training (experimental) will score significantly higher than experienced psychiatric nurses who did not receive internship training (comparison) of basic psychiatric mental health Knowledge. The null hypothesis to this question was: There was no significant difference found between the experimental and controlled groups regarding their level of performance (M_e adjusted=21.35, M_C adjusted=20.90; $F(1,36)=1.2$). The null hypothesis to this question was accepted.

Table 4 presents the ANCOVA summary data.

On the dependent measure NLN subtest assessment, the answer to hypothesis three was: As measured by the National League for Nursing Psychiatric exam, professional registered nurses in the internship group post-training (experimental) will score significantly higher than experienced psychiatric nurses that did not receive internship training (comparison) of basic

psychiatric mental health Assessment/Analysis. The null hypothesis to this question was: There was no significant difference found between the experimental and comparison groups regarding their level of performance (M_e adjusted 34.12, M_c adjusted=33.59; $F(1,36)=.05$). The null hypothesis to this question was accepted.

Summary statistics for this ANCOVA is presented in Table 5.

On the dependent measure NLN subtest evaluation the answer to hypothesis four was: As measured by the National League of Nursing Psychiatric Nursing exam, professional registered nurses in the internship group post-training (experimental) will score significantly higher than experienced psychiatric nurses that did not receive internship training (comparison) of basic psychiatric mental health Evaluation. The null hypothesis to this question was: There was no significant difference found between the experimental and controlled groups regarding their level of performance (M_e adjusted 28.05, M_c adjusted=27.98; $F(1,36)=.00$). The null hypothesis to this question was accepted.

Table 6 presents the ANCOVA summary information. Figure 4 pictorially summarizes the subjects NLN performance.

The results reported above suggest that the experimental and comparison groups demonstrated no significant difference in

their mean age or education. However, there was significant differences found in their levels of psychiatric experience six months and twelve months using the instructor made exam. The sixth research questions was: As measured by the instructor made exam, will professional registered nurses that complete the the internship course (experimental) score significantly higher on the exam six months after the course as compared to their initial levels of learning directly after the course? The null hypothesis to this question was there was no significant difference found on performance on the exam six months after the course compared to their initial levels of learning directly after the course.

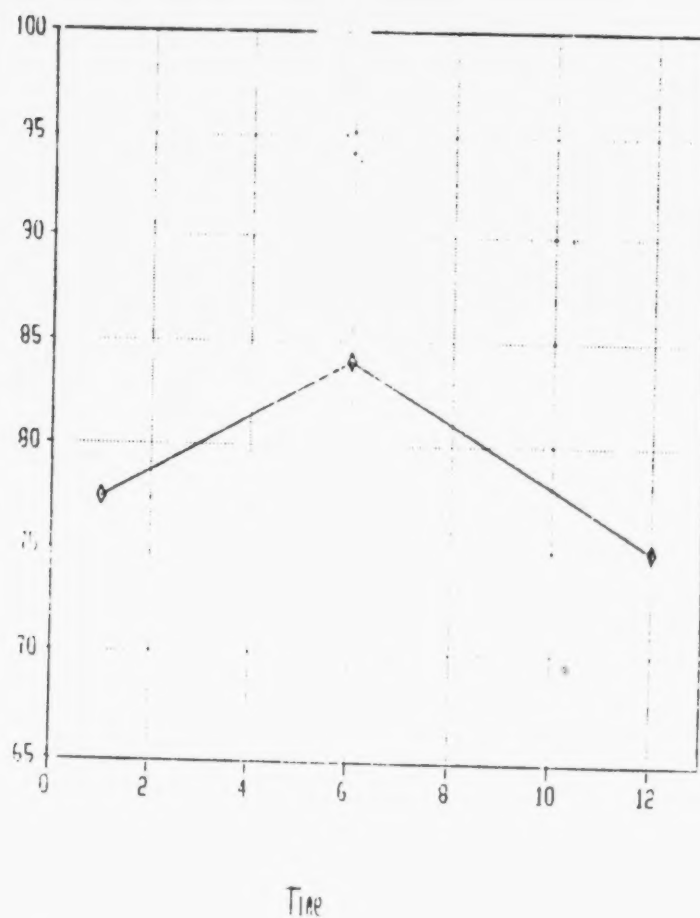
Analysis of the experimental group at the time periods at six months suggest a significant difference on performance of the instructor made instrument. The null hypothesis was rejected. The seventh research question was: As measured by the instructor made exam, will professional registered nurses that complete the internship course score significantly higher on the exam one year after the course as compared to their initial levels of learning immediately after the course? The null hypothesis to this question was there was no significant difference found on performance of the exam twelve months after the course as compared to their initial levels of learning directly after the course. The null hypothesis was rejected. No

other time period comparisons were significant.

Comparing the experimental and comparison groups after statistically controlling for their differing levels of psychiatric nursing experience failed to yield any significant differences on any of the subtests of the NLN.

Graph 1

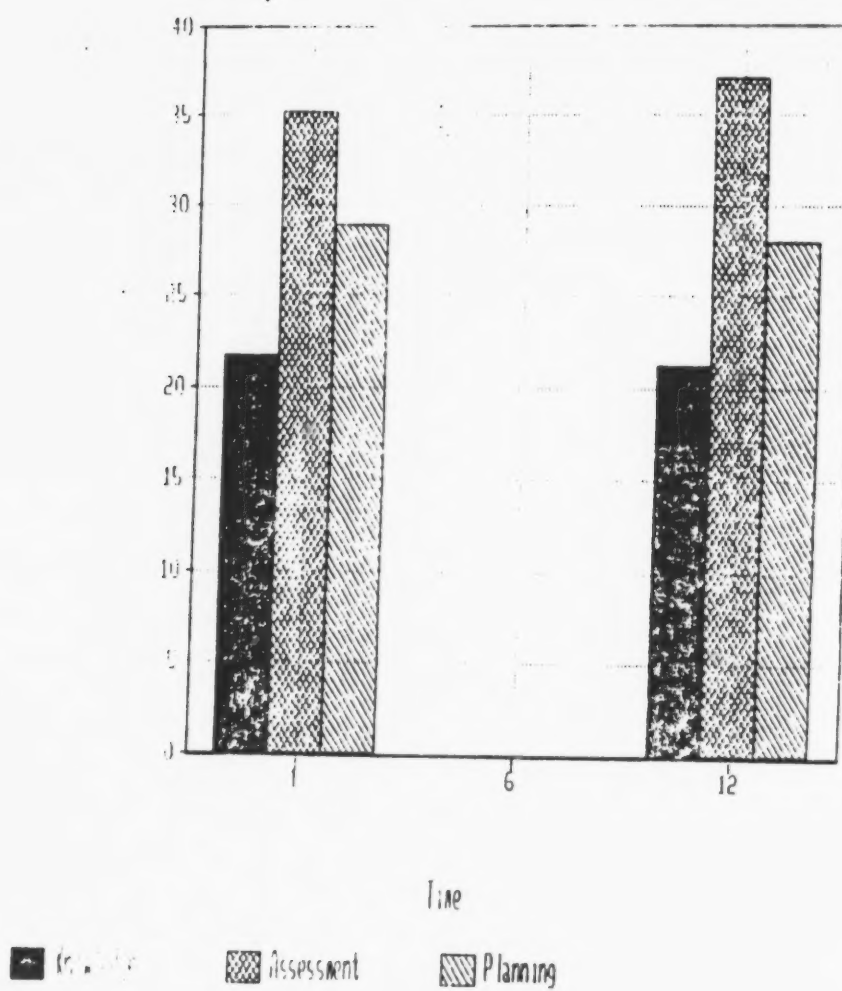
Percent Correct of Lecture Content Test
Experimental Group



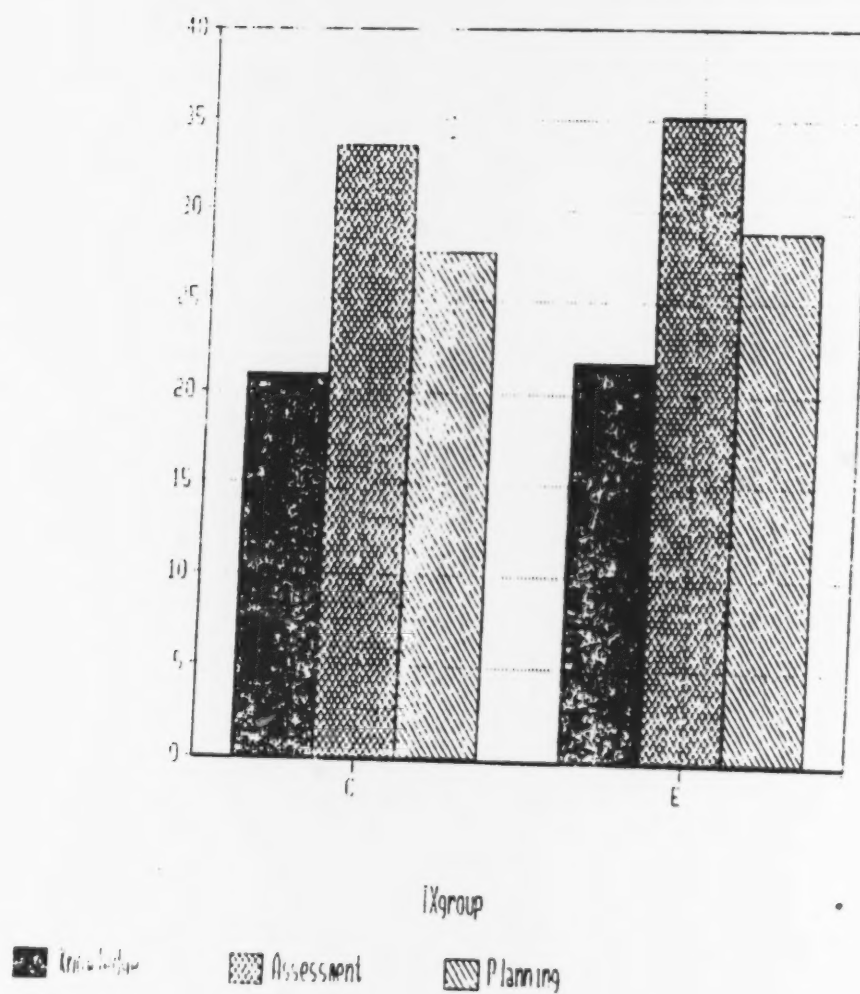
↳ Lecture content

Graph 2

NLN Scores for Experimental Group

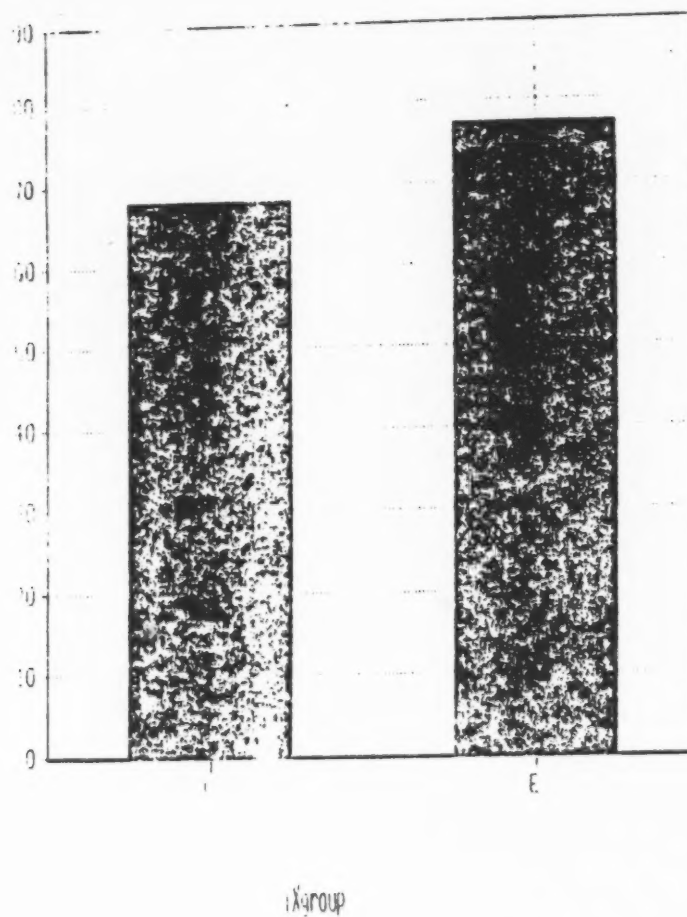


Graph 3
Control versus Experimental on NLN Test



Graph 4

Control versus Experimental On Content at Initial



On Content at Initial

Table 1. Subject's Mean Ages, Education and Psychiatric Nursing Experience by Treatment Group.

<u>Group</u>	<u>N</u>	<u>Age</u>	<u>Education</u>	<u>Experience</u>
Experimental	14	44.62	2.69	1.31
Control	27	42.38	2.65	6.01

Table 2. ANOVA Summary Table for Treatment Group on Psychiatric Nursing Experience.

<u>Source</u>	<u>DF</u>	<u>Sum-Squares</u>	<u>Mean Square</u>	<u>F-Ratio</u>
TxGroup	1	191.92	191.92	7.60**
Error	37	934.66	25.26	
Total	38	1126.57		

** $p < .01$

Table 3. ANCOVA Summary Table for Treatment Group on Lecture Content Test with Psychiatric Nursing Experience as the Covariate.

<u>Source</u>	<u>DF</u>	<u>Sum-Squares</u>	<u>Mean Square</u>	<u>F-Ratio</u>
Experience	1	202.77	202.77	1.29
TxGroup	1	322.53	322.53	2.05
Error	34	5358.35	157.59	
Total	36	6221.62		

Table 4. ANCOVA Summary Table for Treatment Group on MLM Knowledge Subtest with Psychiatric Nursing Experience as the Covariate.

<u>Source</u>	<u>DF</u>	<u>Sum-Squares</u>	<u>Mean Square</u>	<u>F-Ratio</u>
Experience	1	1.11	1.11	0.09
TxGroup	1	1.48	1.48	0.12
Error	36	429.51	11.93	
Total	38	433.89		

**Table 5. ANCOVA Summary Table for Treatment Group on
NLN Assessment Subtest with Psychiatric Nursing Experience
as the Covariate.**

<u>Source</u>	<u>DF</u>	<u>Sum-Squares</u>	<u>Mean Square</u>	<u>F-Ratio</u>
Experience	1	31.35	31.35	0.79
TxGroup	1	1.97	1.97	0.05
Error	36	1434.96	39.86	
Total	38	1482.92		

**Table 6. ANCOVA Summary Table for Treatment Group on
NLN Planning Subtest with Psychiatric Nursing Experience
as the Covariate.**

<u>Source</u>	<u>DF</u>	<u>Sum-Squares</u>	<u>Mean Square</u>	<u>F-Ratio</u>
Experience	1	40.52	40.52	2.57
TxGroup	1	0.003	0.003	0.00
Error	36	568.29	15.79	
Total	38	618.44		

Chapter 5

Discussion, Implications and Recommendation

The subject variables were analyzed statistically to determine if any preexisting conditions existed between the experimental group and comparison groups that may have affected the results. The curriculum under consideration had two main components, the diadactic portion and clinical experience. As reported, the groups were not different on their mean years of nursing education or on their mean ages. The subject variables tested did yield significant differences with the comparison group being clearly more experienced than the experimental group yielding a F ratio of 7.60 with a probability of a type one error less than .01. Because of this unintentional difference between the experimental and comparison groups, in later analyses when comparing those two groups, analysis of covariance was used to statistically correct for difference in nursing education.

The first set of analyses compared the experimental subjects only on the instructor prepared test, comparing the performance at the time periods post-training, at six months and at twelve months after instruction. No significant differences were found in the subjects' performance just after training and six months later than between their initial testing at the end

of training and twelve months later. This suggests that although mean differences did exist during these three time periods (76.85 initial, 84.12 six month, 75.06 twelve months), the experimental design may not have had enough power to allow these values to discern the differences as statistically reliable. The small sample size may have been a significant contributor to the lack of statistical power. The t test between subjects performance at six months and twelve months did show significant difference. A t test for paired samples with degrees of freedom of twelve demonstrated that the probability of a type one error was less than .001. This suggests a reliable decline in information tested by the instructor made test between six months and twelve months post-training. This result may suggest that if there are reliable gains in knowledge as a result of the internship program as measured by the instructor made instrument, a "recharge" session approximately nine months after training may be indicated to help reinforce the knowledge learned and help the nurses retain more information. In addition, it could suggest that after integration on a psychiatric ward, that the knowledge base that these nurses are working from is that which is influenced by the milieu and professionals which may very well be deviant from the knowledge that they learned in the course and accepted nursing practice. At this point that only remains an interesting

hypothesis to be tested by some future researcher.

In the analysis of the NLN instrument, again paired t tests were conducted on experimental subject only on each of the three dependent measures of knowledge, assessment and planning. Between their levels immediately post-training and twelve months later, no significant decline in the nursing trainees knowledge was indicated on these standardized measures. Again, without measurements at the six months period it is uncertain whether or not there was a peak in their knowledge six months after training after being exposed to working on a psychiatric unit. It should be noted that the experimental group was made up of mostly inexperienced nurses with no real psychiatric nursing experience. There may very well have, if there had been data at six months, been an increase after their exposure to day to day nursing practice on a psychiatric unit reinforcing that which they learned in the course. This effect was observed on the instructor made tests. Again, the no differences record between zero and twelve months may be seen as a decline. This again is consistent with the recommendation for a refresher or "recharge" of the taught material at approximately nine months, although that remains highly speculative on the basis of this data. The literature on long-term memory does suggest the need for recharge sessions so material is not forgotten. However, it is not within the scope of this paper to explore this issue with

creater clarity.

The main analyses where the experimental and comparison groups were compared, statistically their difference in nursing experience, the timing of these dependent measures are immediately after the training of the experimental group and with the comparison group. The results on the instructor made tests and the three subtests of the NLN test suggest no significant differences when corrected for experience between the experimental and comparison groups. This is highly disconcerting as this main effect was expected to be strong. The possibility of be dealing with a ceiling effect of knowledge of psychiatric nursing where as the statistical correction for the experience was not enough to override the effects of experience on basic psychiatric nursing knowledge. Another way of looking at this is, that there is not a clear linear relationship between nursing experience and scores on these tests, that there may be a ceiling effect, ie: that after one or two years of nursing experience, there is no longer a linear correlation between additional experience and additional knowledge as tested by these instruments. Extrapolating from that hypothesis the most potent effect of the training would be seen in new nurses. The fact that new nurses with little experience after training had equivocal levels of knowledge of nurse with experience speaks well for the training. It would be

interesting to compare the new trainees six months after gaining some basic experience with the training to a group of nurses without any experience but training, and a group without any training but experience. It cannot be totally dismissed that the validity of the standardized measures used was not concurrent with the material taught and therefore affected this evaluation from detecting the changes that may have occurred in the nurses due to the additional psychiatric nursing training.

Summary of Findings

In conclusion, the result of this evaluation can be best described as failing to support all the hypotheses during this intervention. This may best be the result of efforts to consider questions related to curriculum or program effectiveness in a context of "scientific experimentation" rather than a mere qualitative look at the effectiveness of the curriculum. The interesting finding remains in the fact that although all hard evidence gathered for a scientifically derived evaluation program revealed no significant differences, HCA has continued to maintain the internship curriculum, as it does, in fact, serve as a powerful retention tool that is preventing a nursing shortage in HCA facilities. The use of an internship program is addressed in the Nursing Shortage Reduction Act of 1987 (Appendix A). Another variable that may have negatively effected main hypotheses was possibly methodologically related

in that that the experimental control groups were confounded with years of nursing experience and the lack of additional time periods of testing. The results could be interpreted as suggesting that the standardized training approach used in the study may compensate unexperienced psychiatric nurses for the knowledge that they have not gained on the job and thus would send them to the field better prepared. The performance of the experimental control groups on the standardized instructor made instrument may support this position.

Recommendations for Future Research

Future studies may best be reconceptualized as a longitudinal study. Nursing trainees could be followed as they gain experience on the unit exposing them to additional refresher courses at periodic intervals during their professional careers and assessing the effects on their recoiled knowledge. In addition, knowledge alone does not make a nurse and measurements of supervisor satisfaction and patient satisfaction would be a necessary dimension and have a more holistic view of the effects of education on a nurses performance.

Taking that thought to the next logical step yields to a study designed which uses a discriminate function analysis to separate psychiatric nurses into, by a set of objective criteria, groups of high functioning and low functioning nurses

and find out which variables including knowledge, personality factors, academic achievement and experience contribute in what proportions to the successful versus the unsuccessful psychiatric nurse.

The psychiatric nurse internship program was first implemented in July of 1987. It is interesting to note that two years later, HCA has continued to offer the program biannually.

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APPENDIX ATHE NURSING SHORTAGE REDUCTION ACT OF
1987 S.1402TEXT OF THE BILL AS REPORTED

A bill to amend title VIII of the Public Health Service Act to establish programs to reduce the shortage of professional nurses.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act be cited as the Nursing Shortage Reduction Act of 1987.

ESTABLISHMENT OF PROGRAM

SEC. 2, Title VIII of the Public Health Service Act is amended adding at the end and thereby the following new part:

PART D--INITIATIVES TO REDUCE NURSING
SHORTAGES ADVISORY COMMITTEE

SEC. 861. The Secretary shall establish a special advisory committee to develop a comprehensive plan which specifies long-term solutions to the problems experienced by hospitals and other health care institutions in recruiting and retaining professional nurses. Such committee shall consist of representatives of professional nursing organizations, other health care professional organizational hospitals and other health care providers, and experts in rural health care. Representatives of hospitals and other health care providers on such committee shall include nurses.

INNOVATIVE HOSPITAL NURSING PRACTICE MODELS

SEC. 862. (a) The secretary shall make a grant to a nonprofit private entity with a demonstrated record in supporting innovative health initiatives for a project to demonstrate and evaluate innovative hospital nursing practice models designed to reduce vacancies in hospital nursing positions and to make the hospital nursing position a more attractive career choice. Models demonstrated and evaluated under a grant under this section shall include initiative to:

(1) restructure the role of the hospital nurse through changes in the hospital staff and through innovative approaches for interaction between hospital administration and nursing personnel, in order to ensure that the particular expertise of nurses is efficiently utilized and that nurses are engaged in

APPENDIX B

CURRICULUM

In this unit the range of depression will be considered in order to provide the context for recognizing, understanding, and relating to the various individual clients who manifest depressive behavior.

Organizing the depression on a continuum provides a framework for understanding that depressions may change qualitatively as they deepen or lift. For example, the thought process of a moderately depressed person may be simply slower, whereas the thought process of the same person with deepening depression may change from slowness to distortions of reality.

Unit Objectives

At the end of this unit the student will be able to:

1. Identify the adaptive responses resulting in depression
2. Apply the nursing process to formulate care for depressed clients
3. Evaluate the effectiveness and side effects of anti-depressants
4. Identify adaptive responses demonstrated by physiological manifestations from moderately to severely depressed clients
5. Discuss psycho dynamic, biochemical, genetic and extrinsic factors contributing to altered patterns of mood and affect
6. Compare various therapeutic approaches to working with depressed clients
7. Compare various therapeutic approaches to working with elated clients
8. Describe somatic interventions used with clients experiencing maladaptive alterations of mood and affect
9. Recognize the responsibilities and contributions of the nurse in the administration of somatic interventions

10. Identify nursing functions in preventing and alleviating maladaptive alterations of mood and affect
11. Differentiate adaptive grief from maladaptive responses to loss

CONTRIBUTING OBJECTIVES	CONTENT	LEARNING ACTIVITIES
Explore the meaning and feelings of depression Assess client manifesting reaction to anxiety through depression Analyze the defense mechanisms utilized by the depressed person Describe clients exhibiting altered adaptive responses resulting in suicidal behavior Assess client for suicidal behavior Analyze etiological facts about suicide Plan measures to deal effectively with suicide patient Evaluate effectiveness of care Analyze nursing diagnoses for depressed client Assess clients treatment objectives Formulate care plan for client Identify major treatment modalities for the depressed client Identifies anti-depressant medications which are commonly used to treat the depressed client	VI. <u>Nursing assessment of client with depression</u> A. <u>subjective/objective data</u> 1. subjective data - feelings 2. appearance 3. verbal response 4. physical signs/symptoms 5. masked symptoms 6. behavior B. <u>Defense Mechanisms</u> 1. acting out 2. denial 3. introjection/projection 4. regression 5. repression C. <u>Symptoms of depression with suicidal ideations</u> 1. somatic symptoms 2. motor symptoms 3. ideations 4. work and other interests 5. mood 6. feelings D. <u>Nursing Care Plan & Interventions</u> 1. subjective data 2. objective data 3. nursing diagnosis 4. patient/centered objectives 5. interventions E. <u>Psychotherapies and the Nursing Care Plan</u> 1. Individual 2. family 3. group 4. ECT F. <u>Clients Receiving Anti-depressants and Nursing Implications</u> 1. Tricyclic Derivatives a. Elavil b. Norpramin c. Sinequan d. Aventyl e. Vivactil f. Tofranil	Janosik, E. and Davies. <u>Psychiatric Mental Health Nursing</u>, chapter 7 & chapter 15

CONTRIBUTING OBJECTIVES	CONTENT	LEARNING ACTIVITIES
Recalls generic and trade names for each medication Discusses Rational for MAO inhibitions Evaluates agents contra-indicative during the treatment of MAO inhibitors Determines action and uses of lithium carbonate Recognizes side effects of lithium toxicity Identifies lithium carbonate levels Assesses client clients receiving drugs for depression for side effects Relates major nursing implications of each drug administered to clients	2. <u>Mono-Amine Inhibitors</u> a. marplas Isocarboxizide b. Nardil Phenalzine c. Parnate Tranlylcromine 3. <u>Lithium Carbonate</u> 1. therapeutic levels range from 1.0 to 1.5 mEq per liter VII. Evaluation	Applies nursing process to clients exhibiting severely altered responses to stressors resulting in depression. Collaborates with others in a dependent independent and interdependent role

Altered Patterns of Mood and Affect

Affect means emotion. It is what gives richness and fullness to our lives. Yet, when it ranges too far beyond the limits of reality, it can become a source of overwhelming psychological distress. Such is the case with Affective Disorders, i.e., feelings of sadness or elation become so intense that they reach psychotic proportions.

I. Theories of Affective Disorders

A. Psychological--Depression is viewed as a loss.

The loss can be Exogenous (that which originates from an external cause), Reactive (as a reaction to a real loss), or Endogenous (loss which originates from an internal cause). Endogenous loss according to psychological theorists (Freud, Erikson, Sullivan) refers to the loss of mothers' love (new baby, harsh toilet training). As a result of this, the child grows up feeling anxious, having self-doubt, feels guilty and has a decrease in self-esteem. Abraham and Freud hypothesize that depression is anger turned inward. Psychological theorists hold that mania is a reaction-formation of depression.

B. Sociological, Interpersonal--Studies seem to show that families with children that have affective disorders

are upward striving, but socially, culturally and economically isolated from the community. One parent, usually the mother, is seen as the ultimate authority, but is cold and unloving. Father is warmer, but ineffective.

C. Biochemical--

(1) Related to the transmission of nerve impulses across the synaptic cleft by neurotransmitters, especially biogenic amines. Two altered neuro transmission patterns have been identified:

norepinephrine deficiency in depression and serotonin deficiency in mania and depression (bipolar disorder).

(2) Due to an imbalance of hormones particularly sex hormones (oral contraceptives, pregnancy and menstruation can cause depression).

(3) May originate from imbalances of sodium and potassium levels (Lithium which successfully treats affective disorders achieve their effect by lowering sodium levels).

D. Family Therapy--Depression is a metaphor for the dynamics in the family (child acts out mother's depression--child acts out to shift focus away from troubled family to self in order to save marriage).

E. Biological-Genetic--1% of affective disorders in general population.

15% among first relatives.

20-25% among siblings.

66-96% among identical twins.

F. Cognitive-Becks Theory--Cognitive Triad of Depression.

- (1) Negative view of self
- (2) Negative view of the world
- (3) Negative view of the future

II. Types of Affective Disorders

A. Major Depression-Psychotic Disorder

- (1) Unipolar Depression
- (2) Involutional
- (3) Post-Partum Depression

B. Bi-Polar Disorder-Psychotic Disorder

C. Cyclothymic Disorder-Personality Disorder

D. Dysthymic Disorder-Neurotic Disorder

E. Grief and Mourning-Crisis

F. Mid-Life Crisis Disorder-Crisis

III. Depression

A. Assessment

- (1) Dysphoric mood or loss of interest or pleasure in all or almost all usual activities and pastimes
- (2) The dysphoric mood is characterized by symptoms such as being sad, blue, hopeless, low-down, irritable

(3) Patient has poor appetite-----or increase in appetite

(4) Insomnia-----hypersomnia

(5) Psychomotor agitation-----psychomotor retardation

(6) Has a loss of interest in pleasurable activities

(7) Low energy and feels worthless and guilty

Need to assess suicide potential--ask

(1) Has person tried to commit suicide? If so,

(a) Why? (Intent)

(b) What method?

(c) What time?

(d) Are there any support systems?

Ask

(2) Are you considering suicide now?

B. Myths about Suicide

Myth People who talk about suicide don't commit suicide.

Fact Of any ten people who kill themselves, eight have given definite warnings of their suicidal intentions.

Myth Suicide happens without warning.

Fact Studies reveal that the suicidal person gives many clues and warnings regarding suicidal intentions.

- Myth** Suicidal people are fully intent on dying.
- Fact** Most suicidal people are undecided about living and dying, and they "gamble with death," leaving it to others to save them. Almost no one commits suicide without letting others know how he/she is feeling.
- Myth** Once a person is suicidal, he/she is suicidal forever.
- Fact** Individuals who want to kill themselves are suicidal only for a limited period of time.
- Myth** Improvement following a suicidal crisis means that the suicidal risk is over.
- Fact** Most suicides occur within about three months after the beginning of "improvement," when the individual has the energy to put morbid thoughts and feelings into effect.
- Myth** Suicide strikes much more often among the rich--or, conversely, it occurs most exclusively among the poor.
- Fact** Suicide is neither the rich man's disease nor the poor man's curse. Suicide is very "democratic" and is represented proportionately among all levels of society.

Myth Suicide is inherited or "runs in the family."

Fact Suicide does not run in families. It is an individual pattern.

Myth All suicidal individuals are mentally ill, and suicide always is the act of a psychotic person.

Fact Studies of hundreds of genuine suicide notes indicate that although the suicidal person is extremely unhappy, he/she is not necessarily mentally ill.

C. Nursing Interventions

Depression

- (1) Take routine suicide precautions (*read text on suicide).
- (2) Assist in daily decision making until patient regains self-confidence.
- (3) Prepare warm baths and hot beverages to aid in sleep.
- (4) Give attention to physical needs for food, sleep and hygiene.
- (5) Mild exercise to relax, diversional activities.
- (6) Slowly repeat, simple direct information.
- (7) Do not allow long periods of silence to develop.*
- (8) Initiate frequent contact, do not allow patient to remain withdrawn.

(9) Use a kind, understanding but emotionally empathetic, neutral approach.

(10) Watch for improvement, reassess suicide potential.

D. Defense Mechanisms

(1) Introjection

(2) Regression

(3) Denial

(4) Repression

IV. Mania

A. Assessment

(1) One or more distinct period with a predominately elevated, expansive or irritable mood.

(2) Increase in activity

(3) More talkative than usual

(4) Pressure to keep talking

(5) Flight of ideas

(6) Increase in self-esteem (delusions of grandeur)

(7) A decreased need for sleep

(8) Distractibility

(9) Excessive involvement in activities that have a high potential for painful consequences which is not recognized by patient, i.e., buying sprees, sexual indiscretion.

B. Nursing Interventions

Mania

- (1) Ignore profanity, sarcasm, etc.
- (2) Set limits

Sublimate energy with activities that do not require concentration and do not involve other patients.

Activities that use the strong muscles.

- (3) Attend to personal hygiene and sleep
- (4) Provide high calorie beverages
- (5) Provide finger sandwiches so patient can eat on the run.

C. Defense Mechanisms

- (1) Denial
- (2) Projection
- (3) Reaction Formation
- (4) Acting Out

V. Medication for Depression

Antidepressants (Tricyclics)

Use--Increase mood in depression, increase physical activity and mental alertness may bring relief of symptoms of depression so that patient can participate in therapy, i.e., group therapy.

Side Effects--Activation of latent schizophrenia, tremors, dry mouth and other anticholinergic effects.

Action--Acts to block the reuptake of CNS neurotransmitters such as norepinehrine and serotonin.

Contraindications--

- (1) Must monitor patients with cardiovascular conditions
- (2) Narrow angle glaucoma 3)hx of urinary retention
- (3) Hx of urinary retention
- (4) Benign prostatic hypertrophy
- (5) Seizure disorder
- (6) Impaired liver function

Antidepressants--Monoamine Oxidase Inhibitors MAOs

Use--Used for relief of depression. Used after Tricyclics have failed,---not used first because of the severity of side effects.

Action--Maos are naturally occurring enzymes and metabolize neurotransmitters at the synapse

Side effects--Hypertensive crisis if taken with foods that contain tyramine sympathomimetics

Foods that are contraindicated

meat tenderizers, strong or aged cheeses (cheddar cheese), sour cream, yoghurt, pickles, pickled herring and other canned fish, chopped liver and chicken livers, avocados, bananas, raisins, canned figs, citrus fruits, pineapple, broad beans and their pods, soy sauce, any product containing yeast, beer and wine (particularly chianti and sherry), coffee, chocolate and chicken.

Medications that are contraindicated

narcotic analgesics, amphetamines, L-dopa, methyldopa, phenylpropanolamine (OTC drug remedies), tricyclic antidepressants.

Contraindications

- (1) Patients who are unable to conform to a restricted diet
- (2) Patients that have cerebrovascular defects or cardiovascular disease
- (3) Clients over 60 years
- (4) Liver disease
- (5) Hypersensitivity to MAOs

Antidepressant Drugs

Generic name	Trade names	Usual daily dose (mg.)	Maximum daily dose (mg.)
Tricyclics imipramine	Imavate Janimine Presamine SK-Pramine Tofranil	100-200	300
desipramine	Norpramin Pertofrane	100-200	300
amitriptyline	Amitril Elavil Endep	75-200	300
nortriptyline	Aventyl Pamelor	75-150	150
doxepin	Adapin Sinequan	75-150	300
protriptyline	Vivactil	15-40	60
trimipramine	Surmontil	75-200	400
Monoamine Oxidase Inhibitors			
isocarboxazid	Marplan	10-30	30
phenelzine	Nardil	15-30	90
tranylcypromine	Parnate	20-30	30
Tetracyclics maprotiline	Ludomil	75-300	300
Others amoxapine	Asendin	150-300	400

VI. Medication for Bipolar Disorder

Lithium Carbonate

Use--Treatment for patients with Bipolar disease

Action--Altering the chemical transmitters in the CNS by interfering with the ionic pump mechanisms in the brain cells. A lag period of 7 to 10 days exists between the initiation of lithium carbonate treatment and the alleviation of manic symptoms. During this period, antipsychotic medications should be used.

Side Effects--pulse irregularities, fall in blood pressure, ECG changes, and peripheral circulatory problems. Other side effects include dizziness, blurring of vision, slurred speech, some incontinence of urine or feces. G.I. side effects such as anorexia, n&v, diarrhea, thirst, dryness of mouth and weight loss. *NEED TO KEEP LITHIUM LEVELS BETWEEN 1 and 1.5 meq per liter. If lithium levels are above 2 meq per liter Lithium Toxicity, a serious side effect of lithium can occur.

The first signs of lithium toxicity are blurred vision, ataxia, tinnitus, n&v, increased urination and diarrhea. Other signs include tremors, drowsiness, headaches, confusion, stupor, lethargy, seizures, coma and death.

Nursing Interventions

- (1) Tell patients about the side effects factually and without overemphasis
- (2) Teach patients how to detect and prevent lithium toxicity
- (3) Explain to patients and their families the lag period of up to 3 weeks
- (4) Inform patients that alcohol may potentiate adverse effects of lithium
- (5) Appropriate exercise to decrease weight gain
- (6) Advise patients to avoid conditions that cause profuse sweating
- (7) Advise patients not to increase salt intake
- (8) Advise patients not to eat on an empty stomach

VII. Electro Convulsive Therapy

ECT is a somatic treatment in which a grand mal seizure is artificially induced by passing an electric current through the brain. Current is 70-130 volts. 6-10 treatments.

Use--used in the treatment of depression when patient is unable to take drugs, has a poor response to drugs. The major indication for ECT is depression.

Action--Convulsions start with a tonic spasm of entire body, followed by a series of clonic jerking motions,

especially in extremities. Confusion is present for 30 minutes after treatment. Induces loss of memory for recent events in some patients.

Procedure--Once in the actual treatment room, the patient lies in a supine position on a stretcher. The anesthesiologist administers a short-acting barbituate, such as sodium methohexital, I.V. This is followed immediately by an IV injection of muscle relaxant succinylcholine Anectine, given in separate syringes. Patients are pre-oxygenated with 100% O₂ and their chins are supported to prevent dislocation and provide a more effective airway. A soft mouthbite is sometimes used.

Nursing Interventions ECT

- (1) Always inform patient about the treatment
- (2) Inform patient about the temporary loss of memory
- (3) Follow pre-op procedure
- (4) During the convulsion the nurse should hold the patient in a safe position to avoid dislocation and compression fracture following the seizure
- (5) Post-op nursing measures

Mrs. V. is a 50-year-old female admitted to a psychiatric unit accompanied by her recently married daughter. They describe how over the past 14 years, since the death of Mrs. V's mother, Mrs. V. has become increasingly irritable and difficult to get along with. During the past week she has slept little and spends a great deal of time pacing or rocking in a rocking chair. She refuses to eat. According to her family, she is usually meticulous about her appearance, but on admission she is messy and disheveled. Her husband, visibly upset, describes how the last few days she has been "talking to dead relatives" and how she has "some really crazy ideas about people trying to hurt her." Upon admission Mrs. V. appears confused and frightened. She mumbles incoherently while the family frequently answers questions for her. She has difficulty sitting still and during the admission interview repeatedly gets up to look out of the window into the street.

1. Which of the following are considered myths of suicide?
 - A. Improvement following a suicidal crisis is a good sign the suicidal risk is over.
 - B. Suicides occur without warning
 - C. If a person talks about suicide, he won't commit it.
 - D. Suicidal individuals are only suicidal for a limited period of time.

1. A, B, C 2. A, B, D 3. A, C, D 4. B, C, D
2. When working with a suicidal client, it is important to:
 - A. Not talk about the subject of suicide unless the client brings it up.
 - B. Identify significant others in the client's life.
 - C. Attempt to increase the client's levels of self-esteem.
 - D. Encourage the client's verbal expression of feelings about self and others.

1. A and C 2. A, B, D 3. A, C, D 4. B, C, D
3. Which of the following are considered to be somatic or psychological symptoms of depression?
 - A. Impotence/amenorrhea.
 - B. Apathy
 - C. Angry or aggressive behavior
 - D. Sleep disturbances.

1. A and C 2. B and D 3. A, B, D 4. A, B, D, D
4. A client who is in a depressed mood with reduced motor/cognitive skills has an inappropriate or faulty awareness of reality (e.g. delusions, hallucinations). No overt precipitating cause for the depression can be identified. The client's depression would best be described as:
 1. Bipolar, endogenous, retarded and neurotic.
 2. Unipolar, reactive, agitated and neurotic.
 3. Bipolar, exogenous, retarded and psychotic.
 4. Unipolar, endogenous, retarded and psychotic.

5. Depressed clients often have difficulties resolving feeling of guilt. Such individuals can best be assisted by the nurse:
- A. Changing the subject whenever the client begins to talk about his guilt feelings.
 - B. Talking about the client's perfectionistic and high standards of behavior.
 - C. Avoiding discussion of the spiritual aspects of the client's depression.
 - D. Accepting her own weaknesses and limitations as well as the client's.
1. A and B 2. B and C 3. B and D 4. B, C, D
6. Diagnostic criteria for "major depressive episode" include all of the following except:
- A. Significant change in appetite or weight.
 - B. Change in sleep pattern.
 - C. Increased energy
 - D. Decreased concentration
 - E. Suicidal ideation
7. The term "depression" is used to refer to a :
- A. Feeling
 - B. Disease
 - C. Reaction
 - D. Group of symptoms
1. A, B, C 2. A, C 3. B, D 4. D 5. A, B, C, D
8. The standard pretreatment medications used in ECT include:
- A. Muscle relaxants
 - B. Analgesic
 - C. Barbituates
 - D. Sympathomimetics
1. A, B, C 2. A, C 3. B, D 4. D 5. A, B, C, D
9. Signs and symptoms of mania can include:
- A. Hyperactivity
 - B. Decreased sleep
 - C. Distractibility
 - D. Irritability
1. A, B, C 2. A, C 3. B, D 4. D 5. A, B, C, D
10. Flight of ideas is a thought process characterized by:
- A. Rapid Speech
 - B. Pressured Speech
 - C. Punning
 - D. Goal-Directed Thought
1. A, B, C 2. A, C 3. B, D 4. D 5. A, B, C, D
11. The medication used to treat bipolar disorder is:
- A. Elavil
 - B. Norpramine
 - C. Nardil
 - D. Lithium
 - E. Haldol

12. Mr. J is a 35-year-old steelworker who has been told that he no longer has a job because the company plans to use robots in his department. His initial response is one of disbelief. He then hits the wall and throws all the contents of his locker on the floor. When he gets home he tells his wife that he is out of work, but he really doesn't want to talk about it. Mr. J is exhibiting behaviors characteristic of:

1. Delayed grief reaction
2. Explosive personality
3. Cyclothymic personality
4. Normal grief reaction
5. Mania

There is little demand in the job market for Mr. J's skills. His wife is a nurse, so they decide that she will return to work and he will care for their two small children. Ms. J continues to do the housework and cooking because she views this as "the wife's work." She soon becomes irritable, nags her family, and has episodes of tearfulness. She expresses guilt about her perceived failure to keep the house clean and prepare good meals. The most likely stressor affecting Ms. J is:

1. Identity crisis
2. Role strain
3. Androgyny
4. Loss of dependency
5. Reality shock

13. Ms. J makes an appointment with a mental health clinical nurse specialist in the employee health office. She describes her irritability and tearfulness. She adds that her husband is becoming withdrawn and apathetic. Which of the following referrals would be most helpful for the J's?

1. Refer both Mr. and Ms. J to a gourmet cooking class for socialization and to prepare them to share in household tasks.
2. Refer Mr. J to vocational rehabilitation to evaluate his work skills and help him learn new ones if necessary.
3. Refer both to a family counselor to help them focus on their marital relationship and expectations of self and spouse.
4. Refer Ms. J to a women's group to help her assert herself and reassess her ideas about women's roles.
5. Refer each to a psychotherapist to explore the psychodynamic conflicts that are at the root of their disturbed behavior.

14. Ms. R is a 67-year-old woman who was widowed 6 months ago. Her family was amazed by her fortitude during and immediately after the funeral. She did not cry and she spoke of her husband as if he were still sharing her life. However, she is brought to the emergency room by her son after she told him on the telephone that she was considering an overdose of pills because she could not go on alone. She then began to cry hysterically. The defense mechanism that Ms. R had been using most was:

1. Reaction formation
2. Denial
3. Repression

15. Mr. R is quite distraught over his mother's behavior. He asks the nurse to help him "calm her down". The nurse's BEST response to him would be:
1. "This bothers you more than it does her"
 2. "It's nice that you are so concerned about your mother"
 3. "If you sit quietly with her I'm sure she'll calm down when she gets these feelings out"
 4. "All right, I'll talk with her and see if I can find out what's wrong"
 5. "It's hard to see her so upset, she needs to let the feelings out, we can both stay with her"

Questions 16 to 20 relate to the following situation:

Ms. K is a 48-year-old woman who is admitted to the psychiatric unit of an acute care general hospital after a serious suicide attempt. She got out of bed at 3 AM, obtained her husband's handgun, and tried to shoot herself in the head. The gun jammed and her husband awakened as she was trying to pull the trigger. He brought her to the hospital. He reported that she had seemed despondent, since their youngest child had left for college 2 months ago. Her family physician had been treating her with "vitamin B₁₂ and pep talks." However, she had become progressively more withdrawn, refused food, lost 30 pounds, and neglected her appearance. Mr. K was very concerned about her. She was given a medical diagnosis of major depression.

16. Which of the following nurse interventions would receive highest priority at the time of Ms. K's admission?
1. Interview of Ms. K
 2. Initiation of suicide observation
 3. Administration of prescribed sedation
 4. Orientation to the unit
 5. Introduction to staff and other patients
17. Ms. K tells a staff nurse that she should have died because she is totally worthless. The nurse's BEST response would be:
1. "You have been feeling very sad and alone"
 2. "You feel worthless now but that's a symptom of your illness"
 3. "You really have a great deal to live for"
 4. "I have heard many nice things about you"
 5. "You're sorry you didn't kill yourself?"
18. Ms. K attends activity therapy and is encouraged to pound designs into a leather belt. This intervention is based on which of the following models of serious mood disturbances:
1. Cognitive model
 2. Learned helplessness model
 3. Agression-turned-inward model
 4. Biochemical model
 5. Behavioral model
19. Ms. K's primary nurse discovers that Ms. K is an expert at crewel embroidery. The nurse buys embroidery materials and asks Ms. K if she would teach her crewel work. The BEST rationale for this nursing intervention is:
1. To reinforce Ms. K's identity as a homemaker
 2. To demonstrate that Ms. K is superior to the nurse in manual dexterity
 3. To assess Ms. K's ability to communicate clearly
 4. To discourage Ms. K from thinking about her problems
 5. To utilize Ms. K's strengths to build self-esteem

20. Prior to discharge from the hospital, Ms. K and her husband attend a patient education class on the topic of depression. They are informed of behaviors that could indicate the recurrence of depression. These include all of the following EXCEPT:

1. Insomnia
2. Grandiosity
3. Self-devaluation
4. Suicidal thoughts
5. Psychomotor retardation

Questions 21 to 25 relate to the following situation:

Mr. R is a 38-year-old man who is brought to a state hospital admitting unit for the fifth time. He was arrested after he was observed to be in the nude and riding a horse down the main street of his town. He told the police that he was "Lord Godiva" practicing for his "midnight ride." The police brought him to the hospital where he was admitted under a court order.

21. Mr. R is admitted to the patient care unit at 11:45 PM. While waiting to be examined by the physician he paces the hall rapidly, singing and clapping his hands together. When approached by a staff member, he becomes more agitated. The BEST nursing action at this time is to:
1. Place Mr. R in seclusion until the physician arrives
 2. Insist that Mr. R sit down and wait quietly
 3. Assign one staff member to wait with Mr. R in a closed room
 4. Give Mr. R an intramuscular injection of a tranquilizing medication
 5. Observe Mr. R from a distance and intervene only to prevent physical harm
22. Mr. R's medical diagnosis is bipolar disorder. He says to the nurse, "You can't handle me. I can break right out of here. I have the power of 10 gods. You look very spiritual--like an angel of mercy. Have mercy. Have mercy on me."

The nurse's BEST response to him would be:

1. "I don't understand what you're trying to say"
2. "Do you think about religion very much?"
3. "You're concerned about whether we can help you with control?"
4. "I know you want to leave here, but that's not possible"
5. "It worries me when you make threatening statements"

23. Medication therapy is recommended for Mr. R. The drug that is specifically prescribed for bipolar disorder is:

1. Chlorpromazine
2. Imipramine
3. Lithium carbonate
4. Chlordiazepoxide
5. Phenezine

24. Mr. R informs the nurse that he wants to set a world's record for the highest number of consecutive deep knee bends. He begins to exercise and continues for 1½ hours nonstop. The nurse observes that he is diaphoretic, his face is flushed, and his pulse rate is 150/min. His respirations are labored. He refuses to stop exercising. The BEST nursing action would be:

1. With adequate staff present, inform Mr. R that he must stop or be restrained physically

2. Request help from male staff and place Mr. R in restraints
 3. Explain to Mr. R that he is physically unable to continue
 4. Tell Mr. R. that she has checked the record and he has broken it
 5. Allow Mr. R to continue, but monitor his vital signs carefully
25. As he prepares for discharge from the hospital, Mr. R tells the nurse that he is ashamed of his behavior in the community and worried about facing his neighbors. The BEST response to him would be:
1. "Don't worry. They know you've been sick"
 2. "You were unable to control your behavior so you shouldn't feel ashamed about it"
 3. "They've probably forgotten all about it. Your anxiety makes it seem worse than it is"
 4. "It will be difficult to go back. How might you approach your neighbors?"
 5. "Try not to see other people until you feel comfortable at home"

APPENDIX C

NAME

AGE

SEX

DEGREE

MONTHS OF FULL TIME PSYCHIATRIC NURSING EXPERIENCE

APPENDIX D

Final Exam for HCA Internship Nursing Program

1. Jane Z. calls up the Crisis Hot Line and tells the nurse she wants to die. At this time the nurse could say:
 - A. "Tell me more about it."
 - B. Say nothing and wait for Jane to continue.
 - C. "You called, so part of you wants to live. I can help you."
 - D. Hold on, this is serious. Let me get my supervisor.
2. Crisis can best be defined as:
 - A. a permanent situation that causes damage to the person's self-concept.
 - B. a temporary situation that threatens a person's self-concept.
 - C. a psychotic condition.
 - D. a neurotic condition.
3. The aim of crisis intervention is to:
 - A. restructure the personality.
 - B. remove troubling symptoms.
 - C. repress unconscious drives.
 - D. facilitate an understanding of how the present crisis relates to past ones.
 - E. restore functioning to at least the pre-crisis level.
4. Crisis intervention is based upon the fact that under sudden extreme stress, most people tend to be:
 - A. in control.
 - B. resentful.
 - C. suggestible.
 - D. psychosomatic.
5. What is the most therapeutic attitude to convey to the client in crisis?
 - A. Authority, responsibility and focus on issues relating to the problem.
 - B. Extreme sympathy toward the client's situation.
 - C. Interest in the period of growth and development as this period is connected to the present crisis situation.
 - D. A passive indirect acceptance of the situation.
6. Which of the following statements are true in crisis?
 1. The resolution of a crisis coincides with a change in behavior of the individual.
 2. During crisis, the individual's coping behavior is not successful.
 3. Crisis situations serve as opportunities for emotional growth.

4. A time when habitual problem solving activities are adequate.
5. Points in time that every person experiences in the process of bio-psycho-social growth and development.

- A. 1, 3, 4, 5
- B. 2, 3, 4, 5
- C. 1, 2, 3, 4
- D. 1, 2, 3, 5

7. Which of the following interrelated factors may produce a crisis state?

1. A hazardous event which poses some threat.
2. A threat to instinctual need which is symbolically linked to earlier threats that resulted in vulnerability or conflict.
3. An inability to respond with adequate coping mechanisms.
4. Going to nursing school.
5. Watching soap operas on T.V.

- A. 1
- B. 1, 2
- C. 1, 2, 3
- D. 1, 2, 3, 4
- E. 1, 2, 3, 4, 5

8. Which of the following are factors that influence the outcome of a crisis?

1. Person's perception of the event.
2. Physical and emotional status.
3. Availability of support system(s).
4. Coping (adaptive) capacity available.
5. Genetic endowment.

- A. 1, 2, 3
- B. 2, 3, 4
- C. 3 and 4 only
- D. 4 only
- E. 1, 2, 3, 4, 5

Mrs. T has been admitted to the unit. She enters the unit slowly, with her head down. Her husband keeps urging her to move faster, telling her that "you need to be here because you've been sick." Mrs. T has had a poor appetite, has not been able to sleep, and describes herself as feeling "low down and blue". The nurse notes on the admission sheet that Mrs. T is 39 years old, has no

hospitalization insurance and has been involuntarily admitted. When the nurse asks Mrs. T to come with her, Mrs. T meekly follows along. Her husband turns and quickly leaves the unit.

9. Of the following nursing interventions, which would be best for Mrs. T while her symptoms are severe?
1. Allow her time for quiet thought.
 2. Assist her in daily decision making until she gains her self-confidence.
 3. Ask her to join you and the group in the T.V. lounge for a game of pool.
 4. Take routine suicide precautions.
- A. 1
B. 1, 2
C. 2, 3
D. 2, 4
10. Mrs. T is being interviewed by the nurse. She tells the nurse that life is no longer worth living. The best response the nurse should make is:
- A. "Have you been thinking about suicide?"
 - B. "Let's talk about something pleasant and you'll feel better."
 - C. "What could be so bad to make you feel that way?"
 - D. "We'll talk about your feelings after you have rested."
11. An important part of Mrs. T's mental assessment is her:
- A. economic situation.
 - B. appearance.
 - C. allergies.
 - D. interactions with her roommate.
12. Mrs. T said she lost her job, and then lost her mother. Mrs. T was in state of crisis that would be:
- A. maturational.
 - B. developmental.
 - C. situational.
 - D. all of the above.

Leslie, a nine-year-old girl, was admitted to the medical ward in an acute asthma attack. She has had several asthmatic attacks since the age of three. Her father is an executive who has been quickly moving up in his company. He works long hours and travels a great deal. The family has moved three times in the past year. This attack occurred two days before the family was to move again.

Leslie's mother has been working two jobs and is not consistently in the home. It is important to understand the underlying cause of Leslie's asthma attack.

13. Which of the following principles best describe the psychodynamics of psychophysiological disorders?
 - A. Denial of psychological conflicts is the central mechanism of defense.
 - B. Feelings of dependency, anger, and fear are the primary feelings that are discharged physiologically.
 - C. Secondary gains such as dependency, care or punishment of others are often seen.
 - D. All of the above.
14. Psychophysiologic (Psychosomatic) disorders primarily affect organ systems that are:
 - A. innervated by the autonomic nervous system.
 - B. innervated by the voluntary nervous system.
 - C. innervated only by cranial nerves.
 - D. located above the diaphragm.
 - E. under the direct influence of pituitary hormones.
15. An individual with a psychosomatic disorder usually handles anxiety in all but one of the following ways:
 - A. converting anxiety into a physical symptom
 - B. acting out anxiety with antisocial behavior
 - C. displacing anxiety onto less threatening objects
 - D. regression to earlier levels of adjustment
16. In formulating a nursing care plan for Leslie, your first priority would be to:
 - A. accept that the physical symptoms are real and that Leslie is not faking.
 - B. provide a safe, nonthreatening environment.
 - C. reduce demands on Leslie.
 - D. assess when the symptoms come and go.
17. Mr. Simon, a 34-year-old married clerk, had surgery for ulcerative colitis ten days ago. The physical symptoms have abated, but he continues to complain angrily and to be demanding to the nursing staff. He makes numerous requests such as to open or close the windows, to bring him fresh water, and so on. What may Mr. Simon's behavior be saying?
 - A. "You aren't doing your job."
 - B. "I am alone and helpless and need to depend on you to take care of me when I need you."

- C. "Everyone needs attention."
 - D. "I'm going to get even with you for thinking I'm a crank by making you work."
18. When Mr. Simon asks his doctor about his prognosis, he becomes alternately depressed and agitated about his impending discharge. Which nursing intervention would be best at this time?
- A. "You are much better than when you first were hospitalized. You have to decide whether you need to be hospitalized longer or whether you are ready to go home."
 - B. "You seem to have some concern about going home."
 - C. "What is it about going home that bothers you?"
 - D. "You seem sad about going home. Would you like to talk about it?"
19. Mr. Simon's psychological symptoms will probably show the most improvement when he:
- A. accepts the fact that his physical symptoms have an emotional component.
 - B. finds more satisfying ways of expressing feeling through verbalization.
 - C. becomes involved in group activities and focuses less on his symptoms.
 - D. understands that his current way of reducing stress is not healthy.
20. Coronary heart disease is associated with Type A personality. Individuals such as this tend to have:
- 1. intense drives.
 - 2. preoccupation with deadlines.
 - 3. competitive personalities.
 - 4. self-sacrificing personalities.
 - 5. insecurity with status.
- A. 1, 2, 3, 5
 - B. 1, 2, 3
 - C. 1, 2, 3, 4, 5
 - D. 4 only
21. Which of the following nursing actions is most likely to reduce emotional tension in persons with cardiovascular diseases?
- A. Advising such individuals to live a slower pace.
 - B. Helping them to express feelings of anger, hostility, guilt, resentment and humiliation.
 - C. Suggesting changes in their jobs and home lives.
 - D. Reassuring them and saying, "There is nothing wrong with you."
 - E. Recommending that they take a lengthy vacation.

22. All of the following individuals are likely to develop peptic ulcers except those who are:
- A. worrisome.
 - B. hardworking.
 - C. dependent.
 - D. emotionally expressive.
 - E. driving.
23. After completing this examination, anxiety can most therapeutically be diffused by:
- A. going out drinking with some nursing buddies.
 - B. reliving every question on the test by trying to look up answers to questions remembered.
 - C. swimming, running or doing some form of exercise.
 - D. immediately preparing for the next exam.
24. Mr. Prescott, 28 years old, is admitted to the psychiatric unit. He appears calm and smiles as he answers the nurse's questions. He states that he was in jail a year ago but explains to the nurse that it was a matter of mistaken identity. He is vague about his work, family, and reasons for coming to the hospital. His diagnosis is antisocial personality disorder. From your understanding of psychiatric nursing, you know that all of the following terms are characteristic of the antisocial person except:
- A. very intelligent
 - B. lack responsibility
 - C. easily angered
 - D. strong conscience
25. From your understanding of this illness, you know that Mr. Prescott may best be described as:
- A. an individual of high intelligence who attempts to manipulate people and fails.
 - B. a person with poor superego development who frequently hallucinates to satisfy a developmental lack.
 - C. a person who appears very reasonable who is highly manipulative.
 - D. a person who acts out of fear of punishment.
26. Your objective is to establish a therapeutic relationship with Mr. Prescott. You should be aware that:
- A. Mr. Prescott is psychotic.
 - B. Mr. Prescott may use others for his own purposes.

- C. Mr. Prescott is neurotic.
- D. you must accept Mr. Prescott's behavior regardless of how it is expressed.

27. An important part of your nursing care plan is creating a therapeutic environment for Mr. Prescott. This should include:
- A. a permissive attitude toward Mr. Prescott's behavior.
 - B. use of other patients to set a good example.
 - C. a reasonable amount of limit setting.
 - D. antipsychotic medication as needed.

Nicholas Bonono is a 43-year-old, married man who is chronically suspicious and lacks trust in people. In the past few months, he has become convinced his brother is attempting to steal his property. Although he is still functioning in his position as an accountant, his family, marital, and social relationships have deteriorated. He is admitted to the hospital with a diagnosis of paranoid disorder.

28. Which of the following ego-defense mechanisms are most prominently utilized by Mr. Bonono?
- A. Projection
 - B. Denial and Repression
 - C. Displacement
 - D. Displacement and Repression
29. Since Mr. Bonono is mistrustful of others, which nursing intervention would be most appropriate?
- A. Have him attend many activities, so he will meet as many clients as possible.
 - B. Be very cheerful at all times, so he will sense positive feelings from the nursing staff.
 - C. Be consistent with personnel and schedules, so that structure is provided for his daily activities.
 - D. Utilize touch appropriately to reinforce reality.
30. Robert Benson, a middle-aged business executive, is admitted to the psychiatric unit. He tells the nurse that he came to the hospital because he needs a few days of relief from the constant harassment of FBI. He says they want to steal the plans he has worked out for world peace. Mr. Benson's diagnosis is paranoid disorder. Which of the following is not characteristic of paranoia? (Bordering on psychosis).
- A. Suspiciousness
 - B. Superiority
 - C. Hostility
 - D. Intellectual impairment

31. In order to help Mr. Benson, it is most important for the nurse to do which of the following?
- A. Gather more details about his problems with the FBI.
 - B. Point out to him that his story is not logical.
 - C. Acknowledge his feelings without agreeing with them.
 - D. Explain to him that he will have to learn to live with the existing situation.
32. -Mr. Benson screams at the nurse that a spy is after him. The best nursing response at this time is which of the following?
- A. "You are upset, Mr. Benson. I understand how you feel."
 - B. Ignore his comment.
 - C. "Where are they, Mr. Benson?"
 - D. "Mr. Benson, you are in the hospital now. There are no spies here."
33. Later Mr. Benson refuses to eat his dinner. He says he is hungry, but that his wife is trying to poison him. Taking note that Mr. Benson said he was hungry, which of the following is the best nursing intervention?
- A. Explain that his wife did not prepare the food.
 - B. Call for another tray and eat with Mr. Benson.
 - C. Offer to taste his food before he eats it.
 - D. Arrange to have food in sealed containers served to Mr. Benson.
34. Rodman Dooley is a 45-year-old man, whose wife has accompanied him to the hospital. Mrs. Dooley states that her husband has recently become very suspicious of their neighbors and has almost engaged in physical conflicts with one man on two occasions. He has accused other persons of trying to spy on him, when they are merely going about their own business. In the interview, Mrs. Dooley states that this behavior began a few weeks after Mr. Dooley was on an airplane that was hijacked to another country. The admission officer decided to admit Mr. Dooley for observation. What is the nurse's first priority in working with Mr. Dooley?
- A. Help him to establish one trusting relationship.
 - B. Make him aware of the reality of the situation.
 - C. Improve his self-esteem.
 - D. Improve his social functioning.
35. Mr. Dooley states that he consented to being admitted only to please his wife and that there is really nothing wrong with him. What is the best nursing response?
- A. "Why would she want you here if you didn't need help?"
 - B. "You have been creating some problems for her."

- C. "The only way you will get help is if you admit you need it."
D. "What has been going on in your life lately?"
36. Two nurses are discussing Mr. Dooley's progress, when the client unexpectedly walks around the corner and overhears his name. He says, "What were you saying about me?" Which is the best response for the nurse to make?
- A. "We were discussing your progress."
B. "We often talk about clients."
C. "It would be better if we didn't talk about it."
D. "Does it bother you that we talk about you?"
37. The pedophile's choice of a sex object is primarily based on:
- A. feelings of tenderness toward children.
B. fears of incestuous impulses.
C. preference for a passive sexual role.
D. difficulty relating with adults.
38. An individual who finds sexual satisfaction by dressing in the clothing of the opposite sex is a(n):
- A. Homosexual.
B. Exhibitionist.
C. Transvestite.
D. Voyeur.
39. The most effective approach to prevention of sexual deviance in children is:
- A. positive parent-child relationships in a healthy family setting.
B. consistent and tactful approach to sex education in the schools.
C. early detection and treatment of conflictual sexual identification.
D. redirection of aggressive and sexual impulses into appropriate channels.
40. Which one of the following factors is most critical to successful treatment of a person with sexual deviant behavior?
- A. Avoidance of legal involvements.
B. Money available for treatment.
C. Motivation to change.
D. Fear of disclosure.
41. Clients who are hospitalized for antisocial acts can benefit most from which one of the following environments?
- A. Structured
B. Stimulating

- C. Permissive
 - D. Punitive
42. Which one of the following most characterizes the adult who engages in antisocial acts?
- A. Anticipatory anxiety
 - B. Charismatic personality
 - C. Criminal behavior
 - D. Sexual acting-out
43. A person who consciously fabricates stories to impress others and to get out of compromising situations is:
- A. rationalizing.
 - B. cheating.
 - C. projecting.
 - D. lying.
44. Which one of the following nursing diagnoses is least applicable to the antisocial individual? Social isolation related to:
- A. unaccepted social behavior.
 - B. inability to engage in satisfying personal relationships.
 - C. unaccepted social values.
 - D. deficiency in intelligence.
45. In response to a client's manipulative acts the nurse should provide:
- A. reasonable punishment.
 - B. permissive atmosphere.
 - C. friendly manner.
 - D. consistent limits.
46. Doug, a new patient in the psychiatric ward where you work, had just spent twenty minutes telling you his sad history. He told you that he had been wounded in Vietnam, his wife had left him, and his friends had deserted him. After checking his chart, you learned that all these stories were untrue. You would suspect which of the following diagnoses?
- A. Depressive personality
 - B. Paranoid personality
 - C. Antisocial personality
 - D. Neurotic personality
47. Doug has been certified for fourteen days on the locked unit. While there he becomes friendly with a very disturbed young woman and convinces her to escape with him when a visitor comes through

the locked door. This is an example of impairment in which of the following areas?

- A. Judgement
 - B. Emotional response to others
 - C. Unconscious processes
 - D. Intellectual development
48. Doug is constantly trying to manipulate the staff as a way of getting his needs met. Which response to Doug would indicate that the nurse understands the psychodynamic principle behind the manipulation?
- A. "Doug, I won't allow you to manipulate me."
 - B. "Doug, I won't be able to do as you ask, but I will stay with you and talk."
 - C. "Doug, if this behavior doesn't stop, I shall have to tell your doctor."
 - D. "Doug, let's focus on your anxiety so we can deal with all this manipulation."
49. While persons convicted of felonies are usually put in prisons, many of them have underlying emotional problems. Probably the most common diagnosis seen in prisons would be:
- A. Psychotic personality
 - B. Personality disorder - Antisocial personality
 - C. Paranoid personality
 - D. Adolescent adjustment
50. Some major problem areas that many borderline clients demonstrate include all except which one of the following?
- A. A rigid delusional system
 - B. Chronic boredom
 - C. Rapidly shifting ego states
 - D. Omnipotence of self with devaluation of others
 - E. Splitting
51. Generally, long-term hospitalization is not recommended for borderline clients. The rationale for this is that:
- A. it is expensive.
 - B. borderline clients tend to be manipulative of staff members.
 - C. it may foster regression.
 - D. drug therapy is contraindicated.
 - E. the condition is not a serious one.
52. Gunderson and Singer presented in their extensive review of the literature on borderline pathology six descriptive features of the disorder. Which term in the following list is not one of these descriptive features?

- A. Intense affect
 - B. Impulsive behavior
 - C. Primitive personality organization
 - D. Disordered interpersonal relationships
 - E. Chronic psychosis
53. Group therapy for borderline clients is valuable for all of the following reasons except one. Which one is not a rationale?
- A. There is opportunity for reality testing within the group.
 - B. There is opportunity for individuation through supportive, trusting relationships.
 - C. Aggressive drives can be channeled through problem solving.
 - D. There is ample opportunity for undiluted and direct confrontation of individuals.
 - E. Splitting and projective identification are ideally handled within the group.
54. Passive-aggressive personality disorder is frequently associated with:
- A. obstructionism, stubbornness, and deliberate inefficiency.
 - B. anger.
 - C. depression.
 - D. well adjusted life.
55. Failure to grieve can result in which of the following affective disorders?
- A. Mild chronic depression
 - B. Severe depression
 - C. Schizophrenia
 - D. Psychosomatic disorders
 - E. All of the above
56. Which of the following is the behavior most typical of a passive-aggressive personality?
- A. Angry questioning of why a certain meeting is necessary
 - B. Refusing to attend a meeting that is considered unnecessary
 - C. Attending an unnecessary meeting but not participating
 - D. Conducting a well-reasoned defense of the purpose of a meeting
 - E. Taking a telephone poll soliciting support for cancelling a meeting.
57. All of the following personality traits are characteristic of an obsessive-compulsive personality except:
- A. orderliness
 - B. creativity
 - C. perfectionism

Ellen Evenson is a 20-year-old woman admitted to the psychiatric hospital after attempting to kill her 16-year-old sister, Tanya, by pushing her out of a second-story window. Her only explanation was, "She got in my way." She displays no remorse, nor any attachment to her family, and has a history of truancy and inability to retain employment. Both parents work full time and have been unable to provide close supervision.

70. Soon after Miss Evenson has been admitted to the unit, she shows interest in a young male nurse who is assigned to her. She is charming and cooperative and frequently says to him, "I'm so glad you're my nurse. You're the best nurse on the unit." Which of the following statements provides the best interpretation of Miss Evenson's behavior?
 - A. She has finally found someone for whom she feels a real attachment.
 - B. She recognizes the superior ability of this particular nurse.
 - C. She is proficient at getting her way at the expense of others.
 - D. She is demonstrating a willingness to change, so that a personal relationship with this nurse would be possible.
71. One day Miss Evenson's sister comes to visit her. Miss Evenson says, "She can come in if she wants to. I really don't care." This best demonstrates what combination of responses common to the antisocial personality?
 - A. Concern, apathy, autism
 - B. Suspicion, retardation, isolationism
 - C. Passivity, guilt, remorse
 - D. Superficiality, impulsivity, irresponsibility, apathy
72. Which of the following statements most accurately describes factors contributing to the character of Miss Evenson?
 - A. There was ample opportunity for involvement with appropriate role models, but she chose to avoid close relationships.
 - B. Early needs for security and love were met, but later associations with parents were distant.
 - C. Impaired superego development occurred owing to her lack of internalizing the values of parental figures.
 - D. Much of her lifelong pattern of difficulty is a result of below-average intelligence.
73. Clients with personality disorders:
 1. are fairly easy to treat.
 2. possess an inability to postpone gratification.

- 3. do not feel anxiety or guilt.
- 4. rarely use drugs and alcohol.

- A. 1
- B. 2, 3
- C. 2
- D. 1, 2, 3

Mr. T. is an executive in an advertising agency. He is admitted to the emergency room complaining of chest pain. He attributes his discomfort to indigestion resulting from lunch at a Mexican restaurant. However, the physician's evaluation reveals that Mr. T. has had a myocardial infarction.

74. Mr. T. is informed that he is to be admitted to the coronary care unit. He says, "This is ridiculous. I can't stay here. I have an important meeting this afternoon." Which coping mechanism is he using?
- A. Compensation
 - B. Denial
 - C. Regression
 - D. Repression
75. Mr. T. is admitted to the hospital. He tells Ms. M., the admitting nurse, that he must have a telephone in his room. When she informs him that this is not allowed in the critical care unit, he angrily demands to see his doctor. The best response for Ms. M. to make is to:
- A. assist him to discuss the impact of being ill.
 - B. debate with him about his need for a telephone.
 - C. leave to call the doctor.
 - D. try to arrange for him to have a telephone.
76. A patient was admitted to your medical unit complaining of paralysis of his legs. Extensive tests and workups confirmed his disability but failed to indicate any underlying organic pathological condition. This is most suggestive of which of the following disorders:
- A. Conversion disorder
 - B. Hypochondriasis
 - C. Malingering
 - D. Somatization disorder
77. You are a nurse working in an outpatient department clinic. Your next scheduled patient is Ms. Lee, a woman with a long medical history including numerous visits to different doctors and clinics. After reading her chart and examining her, you realize she has numerous symptoms and fears of many illnesses but no actual impairment. This is most suggestive of which of the following disorders?

- A. Conversion disorder
- B. Hypochondriasis
- C. Hysteria
- D. Psychosomatic disorder

While you are caring for Tommy, a 6-year-old boy, his mother tells you that he is a frequent patient in the pediatric outpatient clinic for his asthmatic attacks. As part of your nursing assessment, you ask about his relationships with his siblings. Tommy says that he gets along fine with his 4-year-old sister, but his mother tells you that they fight constantly about anything at all. She continues to explain how "trying" Tommy is for her, and she's not sure whether she's handling things right. Tommy appears annoyed at his mother's remarks and begins breathing more heavily.

78. In formulating your nursing care plan, you realize that asthma is considered to be a psychophysiological disorder in which a basic defense mechanism used by the patient is:
- A. Displacement
 - B. Projection
 - C. Regression
 - D. Repression
79. According to Rush, the realization that others experience the same thoughts, feelings, and problems is labeled:
- A. Catharsis
 - B. Existential factors
 - C. Instillation of information
 - D. Universality
80. The optimum number of clients in a group is:
- A. 2-4
 - B. 4-7
 - C. 7-10
 - D. 10-15
81. Group maintenance functions are aimed at:
- 1. accomplishment of the task.
 - 2. increasing feeling of security.
 - 3. promoting cohesiveness.
 - 4. expression of feeling within the group.
- A. 1 and 2
 - B. 1 and 3
 - C. 1, 3, 4
 - D. 4
 - E. All of the above.

82. An effective group leader promotes cohesiveness by:
- A. avoidance of commitments about attendance on the part of group members.
 - B. establishment of ground rules about appropriate behavior.
 - C. fostering participation by all members.
 - D. limiting the expression of negative feeling within the group.
83. Which of the following statements is consistently true in Crisis?
- A. Any crisis involves major loss of reality contact.
 - B. Any crisis causes loss of significant relationships.
 - C. Any crisis causes some new strengths to emerge.
 - D. Any crisis involves some degree of loss.
84. Intervention for a client unable to make sufficient changes and thus avoid a maturational or developmental crisis may include all of the following except:
- A. helping the client avoid stressful experiences.
 - B. talking with those in reciprocal roles to the client.
 - C. helping the client realize certain goals will not be achieved.
 - D. discussing the client's fantasies regarding the future.

The next two questions relate to the following situation. M.B. was raped and has multiple knife wounds. Forty-eight hours after hospitalization her condition report says "satisfactory". She has been irritable and demanding of nursing staff and is requesting discharge. M.B. has not talked about the rape event except during emergency admission procedures. When her nurse offered an opportunity to talk about the rape, she responded: "What's done is done. It's history. I've got final exams tomorrow. Would you just help me get discharged?"

85. M.B. is probably experiencing the phase of crisis known as:
- A. impact or shock phase.
 - B. outward adjustment or defensive retreat phase.
 - C. recoil or acknowledgement phase.
 - D. resolution or adaptation phase.
86. The nurse's best response is:
- A. "M., a discharge right now is not a good option for you."
 - B. "M., I guess you'd like to believe the rape has changed nothing and just get on with your future."
 - C. "M., you can't run from the past. All that pain has to be faced, doesn't it?"
 - D. "M., it sounds as though you have a healthy outlook and are ready to get on with your life."

87. Unique characteristics of telephone crisis work are:
1. The nurse-therapist is usually in control.
 2. The client is usually unknown.
 3. The nurse-therapist is usually unknown.
 4. There often are geographic and personal barriers between client and nurse-therapist.
- A. 1 and 2
B. 2, 3, 4
C. 1, 2, 3, 4
D. None of the above.
88. A space shuttle explodes with seven crew members aboard. This event is suggestive of which type of crisis?
- A. Behavioral
B. Developmental
C. Maturational
D. Situational
89. The theory that there are eight stages of psychological development from infant to old age is representative of which of the following individuals?
- A. Erikson
B. Freud
C. Havinghurst
D. Sheehy
90. All of the following characteristics describe crisis intervention except:
- A. Focal.
B. Here and now oriented.
C. Nondirective.
D. Long Term.
91. Which of the following phrases is most suggestive of the major goal of crisis intervention?
- A. Decrease anxiety
B. Facilitate personality
C. Identify the precipitating event
D. Return client to pre-crisis level of functioning
92. Which of the following are symptomatic of early infantile autism?
1. disturbances in speech
 2. more interested in mechanical objects than people
 3. head banging and body rocking
 4. unable to tolerate brief separations from mother

- A. 1 and 2
 - B. 2 and 3
 - C. 1, 2, and 3
 - D. 1, 2, 3, and 4
93. In working with the child with school phobia, the most appropriate nursing intervention is to:
- A. ignore the absence from school
 - B. request the school to change the child's teacher
 - C. encourage parents to accompany the child to school daily
 - D. acknowledge the child's physical complaints, while firmly requiring that the child return to school
94. Characteristics of anorexia nervosa include severe reduction in food intake, frequently accompanied by:
- 1. amenorrhea
 - 2. abnormal thyroid function
 - 3. distorted body image
 - 4. obsessive thoughts about food
- A. 2 and 3
 - B. 1 and 2
 - C. 1, 2, and 3
 - D. 1, 3, and 4
95. Which drug classification is used for its paradoxical effect with children?
- A. hypnotics and sedatives
 - B. antipsychotic agents
 - C. antianxiety agents
 - D. psychostimulants

CASE STUDY:

John, a 15-year-old only child, was admitted to a psychiatric inpatient facility on a referral from the family physician. He was diagnosed as having a knowledge deficit or impaired communication.

John is a tenth grader in a local public high school. Until this year, he has been a "good" student and was on the honor roll; however, this year his grades have dropped drastically. John and his parents met with a guidance counselor who suggested that John is a capable youngster but seems to have "lost interest" in school.

John has functioned well at both school and home until this year. For the past 2 to 3 months there has been a change in his mood,

behavior, and appearance. He has "skipped" school several times and on three occasions recently has threatened to set fire to his house. Each of these threats came about after he had been restricted because of his refusal to carry out his assigned chores. His parents became alarmed because of the increasing frequency of the threats and called their physician.

96. John's threat to set fire to the house may be an attempt to:
- express his repressed sexual feelings.
 - impress his friends.
 - bully his parents.
 - force his parents to recognize his emerging independence.
97. Which of the following would be nontherapeutic when developing a plan of care for John?
- Consistency in carrying out nursing activities
 - Setting realistic goals for John
 - Allowing John to participate in setting goals for himself
 - Allowing John to dictate his treatment plan
98. Which of the following would not be an appropriate goal in working with John?
- To promote physical safety
 - To promote expression of thoughts and feelings appropriately
 - To allow John to drop out of school
 - To establish a balance in activity, diet, sleep, and exercise
99. A nursing care plan for a child with an eating disturbance might include:
- exploration of the parents' expectations.
 - education concerning normal growth and development.
 - serving small portions of food that will enable the child to eat when the parent insists.
 - expecting the child to eat foods that they may not like because this helps them to develop a broader range of tastes.
- 1, 4
 - 2, 4
 - 1, 2
 - 3, 4
100. The most important areas for the nurse to consider when planning care for the client with a degenerative disorder are:

1. obtaining maximum ability.
2. controlling inappropriate sexual behavior.
3. comfort and adaptation for both family and client.
4. gait training.

- A. 1, 3
- B. 2, 3
- C. 2, 4
- D. 1, 4

101. Degenerative disorders are:

- A. found primarily in elderly persons.
- B. are seen less frequently than in the past.
- C. are caused by the aging process.
- D. are increasingly the subject of research interest.

102. Which of the following measures would be employed by the nurse in attempting to build self-esteem of the aged person?

1. Encourage patient to undertake responsibility where success is a reasonable expectation.
2. Give liberal praise for accomplishments.
3. Provide at least one new learning experience daily.
4. Encourage patient to do as much as possible for self.

- A. 1 and 3
- B. 1, 2, and 3
- C. 1, 2, and 4
- D. 1, 2, 3, and 4

103. Neurobiology of aging:

1. begins with neuronal changes.
2. results in increased transmission of neurochemicals.
3. is associated with senile plaques.
4. creates permanent changes.

104. Alzheimer's Disease is characterized by:

1. starch-like protein developing at neuronal junctions.
2. disruption of intellect.
3. a decline in enzymes.
4. muscular rigidity.

- A. All of the above.
- B. 1, 2, 4
- C. 2, 3
- D. 1, 2, 3

105. Memory impairment in the client with Alzheimer's Disease:

- A. develops quickly especially concerning past events.

- B. develops slowly with recent events most affected.
- C. is easy to detect because clients cannot think logically.
- D. is not of importance for this disorder.

106. Huntington's Chorea:

- 1. is a hereditary disease.
- 2. develops slowly with changes in emotional liability.
- 3. causes concern over sexual behavior.
- 4. may be misdiagnosed as mania or schizophrenia.

- A. 2, 3
- B. 1, 3, 4
- C. 2, 3, 4
- D. All of the above.

107. The development of family theory was influenced by observation that:

- A. virtually all members of a family interact as one unit.
- B. family interactions may cause a client's dysfunction.
- C. Florence Nightingale had bitter feelings about her family.
- D. families of clients with schizophrenia have distorted communication.

SITUATION:

The Jamisons arrange for family therapy with a nurse-therapist because their middle daughter has run away from home. Their girls are 17, 15 and 14 years old. The oldest girl is in danger of not graduating from high school because of truancy and poor grades. The youngest girl presents no problems to the parents at this time, according to the parents. Mr. and Mrs. Jamison have been married for 17 years, marrying in their senior year of high school because Mrs. Jamison was pregnant. They have separated twice during their marriage, reuniting the last time just 6 months ago. Mr. Jamison is the produce manager at a local grocery store; Mrs. Jamison has never worked outside the home.

Answer the next three questions based on the situation above.

108. Which of the following nursing diagnoses is most appropriate for beginning work with the Jamison family?

- A. ineffective family coping; disabling, related to history of marital separations
- B. ineffective family coping; compromised, related to a runaway child and a child's failing school
- C. anticipatory grieving related to children's leaving home
- D. alteration in parenting; actual, related to lack of control over children

109. Which of the following goals is most appropriate for beginning work with the Jamison family?
- A. Each family member will state what he or she thinks and feels about the daughter's leaving home.
 - B. Each family member will say one supportive thing to another family member each day between therapy sessions.
 - C. The parents will state what it was like for them during their marital separations and why they came back together.
 - D. The nurse will support each family member's existing strengths.
110. An important intervention with the Jamison family initially would be to:
- A. help the parents gain an understanding of their troubled relationship and its impact on their girls.
 - B. support the oldest girl who is still at home and who is manifesting currently the most symptoms of distress.
 - C. promote alliances between each parent and one of the remaining girls in order to strengthen the family.
 - D. differentiate between the crisis of a runaway child and the longer-term problems of the family.

SITUATION:

The nurse is assigned to care for Mr. Bishop, a 39-year-old hyperactive, elated patient who exhibits flight of ideas.

111. The nursing care plan for Mr. Bishop should appropriately include plans to:
- A. encourage him to talk as much as needed.
 - B. arouse and focus his interest on reality.
 - C. persuade him to complete any task that he begins.
 - D. provide constructive channels for redirecting his excess energy.
112. Mr. Bishop is not eating. The nurse recognizes that this may be because he:
- A. feels that he does not deserve the food.
 - B. believes that he does not need the food.
 - C. wishes to avoid the patients in the dining room.
 - D. is so busy he does not take time to eat.
113. Biochemical factors of altered patterns of mood and affect include:
- 1. transmission of nerve impulses across the synaptic cleft.
 - 2. norepinephrine and serotonin increases and decreases.

3. dominant genes that are unpredictable.
 4. nutritional disturbances.
- A. 1, 2
 - B. 1, 2, 4
 - C. 2, 3, 4
 - D. 1, 2, 3, 4
114. In planning care for a client with an altered pattern of mood and affect, the nurse should include:
1. suicidal assessment.
 2. exploration of somatic complaints.
 3. attention to G.I. functioning.
 4. structured tasks to allow completion.
- A. 1, 2, 4
 - B. 2, 3, 4
 - C. 1, 4
 - D. 1, 2, 3, 4
115. Depression negatively alters:
- A. sleeping, eating, and pleasurable activities.
 - B. leukocyte production.
 - C. production of RBC.
 - D. amount of nerve cells in brain transmission.
116. The nurse caring for a client with mania should know that:
1. the clients frequently exhibit delusions of grandeur.
 2. the ego of the client is strong and defended.
 3. the disorder enables the client to feel less need for sleep.
 4. nutritional status of the client may be at risk.
- A. 1, 2, 4
 - B. 2, 3, 4
 - C. 1, 3, 4
 - D. 1, 2, 3, 4
117. If a client is about to receive ECT, the nurse should tell the client that:
- A. the procedure will not affect her orientation.
 - B. the client will be given a short-acting anesthetic.
 - C. it will be necessary to remove the client's dentures.
 - D. memory loss will follow.

118. Clients who are taking an MAO inhibitor should be told that:

1. certain foods cannot be eaten.
2. the effects will not be experienced for one to two weeks.
3. medications such as cold remedies and decongestants should be avoided. (Sympathomimetics)
4. side effects include hypertensive crisis.

- A. 1, 2, 4
- B. 1, 2, 3
- C. 2, 3, 4
- D. All of the above.

119. Side effects of antidepressant drugs include:

1. tremors, dry mouth.
2. tachycardia, hypertension.
3. bradycardia, constipation.
4. constipation, diaphoresis, and activation of latent schizophrenia.

- A. 2, 4
- B. 1, 4
- C. 2, 3
- D. All of the above.

120. Side effects of lithium carbonate include:

- A. pulse, irregularities and hypertension.
- B. hypotension, nausea, vomiting and diarrhea.
- C. weight gain and depression.
- D. heightened anxiety.

121. Lithium levels must be maintained between:

- A. .5 - .8 mc2/liter
- B. .01 - 1 mc2/liter
- C. 1 - 1.5 mc2/liter
- D. 2 - 4 mc2/liter

122. A mental health team plans to start a beginning aerobic exercise class 5 days a week for depressed clients who have the consent of their physician. Why will this intervention be effective? (Best answer.)

- A. Exercise relieves tension and produces a sense of self-worth and self-control.
- B. It will result in weight reduction and control, which are valued by society.